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J. FULTON, M.D., M.R.C.S. ENG., L.R.C.P. LOND.

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TREATMENT OF RECENT WOUNDS.

BY D. L. PHILIP, M.D., BRANTFORD, ONT.

So many and various methods have been advocated and adopted in recent years of treating wounds, that the young and inexperienced surgeon may be pardoned if at times he is somewhat in doubt as to the best method to employ. In considering this subject three points may be chiefly dwelt upon: Sutures and other methods of uniting wounds; drainage; and antiseptics.

The Sutures.—The materials recommended and used for this purpose have varied from time to time, but there are only four with which we need concern ourselves—wire, silk, catgut and horse-hair. Adhesive plaster may also in some measure be deemed a suture, (by the older surgeons it was termed a dry suture) and is sometimes employed for bringing together the edges of wounds, or affording them support, so as to prevent any strain upon the tissues. The following are Mr. Lister's directions as to the manner of using it:—"If strapping is required, common adhesive plaster may be rendered antiseptic by dipping it for a second or two in a watery solution of the acid, and it is most convenient to have the lotion hot, (say one part of one to twenty, to two parts boiling water) so that the strap is warmed at the same time by its immersion. It can then be effectively applied under the spray, etc."

Metallic sutures so rarely cause any irritation that they may be inserted very near each other with impunity. Sutures far apart with gaping intervals are comparatively useless. If the cut surfaces are to adhere they must be brought into contact and kept there, and for this purpose metallic sutures half an inch apart or even less, are most effi-

cacious. An extended experience has quite borne out the non-irritating character of silver wire as a suture, and though the objection is the difficulty of its removal, yet it is very generally adopted. Iron wire was used and recommended by Sir James Simpson, both for its physical qualities and its cheapness, but it has now fallen into disuse, and the silver wire has taken its place. The objection to the use of the metallic sutures is the tension to which they sometimes give rise; to obviate this, it is advisable in certain cases to make use of sutures which can be absorbed by the tissues, and to a large extent this is accomplished by carbolised or chromicised catgut. If the tissues are lax and union by the first intention takes place, the new material which unites them is sufficiently strong in three or four days to resist the normal elasticity of the skin; in such cases a fine catgut would last for the required time, but as from exudation of blood or serum, or other causes, either the union may be delayed or the tension somewhat greater, the catgut must be of such a quality and thickness as to secure it from absorption for a week or over. The fact is, if a wound be perfectly lax sutures are of use only in maintaining steadiness, while, on the other hand, if the tension is such that the wound requires support against it after the first week, any ordinary suture which may have been left in will cut its way through the skin, and so far from doing good will add to what inflammatory action may be present. Carbolised silk sutures were introduced by Lister by having the ordinary surgeon's silk carbolised. Prepared in this way carbolised silk showed itself preferable to catgut as less amenable to absorption and superior to wire, not only on account of its perfect suppleness but because of its actively antiseptic character, and ensured absence of putrefaction in the track of the stitch.

Catgut Sutures.—These sutures are made of the carbolised gut used for ligatures, and are very serviceable for suitable cases; but they are very soon absorbed and will not last beyond a few days. It is however this power of being absorbed that has given catgut its wide range of utility, especially for uniting deep-seated tissues, where it can be cut short and left undisturbed, the parts above it being allowed to heal. A suture or ligature prepared by treating catgut with chromic acid—chromicised catgut—has been prepared by Dr. McEwan, Glas-

gow, and bids fair to accomplish useful purposes. It resists the action of the tissues much longer than the carbolised gut; in the shape of deep as well as superficial sutures it has been tested by leading surgeons many times, and will in most cases resist the action of the tissues for a fortnight or over, and produce no appreciable irritation. Three important questions arise regarding the efficiency of any suture, does it produce irritation in the tissues, how long does it act efficiently as a ligature, and when does it become absorbed? In determining the point of the length of time which it will maintain its hold in the tissues before being softened, it was employed as a deep stitch in 31 instances; the earliest time it was found softened was nine days, the longest nineteen, the average fourteen; it disappears about the 20th day. It is eventually absorbed by the tissues as is evidenced by their action on the chromicised stitches.

The Drainage.—Drainage is in many respects an admirable procedure and in some respects the recognition of the principle it involves is one of the most marked improvements in modern surgery. But there is little doubt that its use has been carried too far; in suppurating and septic wounds it may easily become a source of irritation.

India Rubber Tubes.—The introduction of systematic drainage of wounds was due principally to Chassaignac, who effected his purpose by the use of India rubber tubes, which bear his name. There are, however, certain disadvantages connected with their use; they cause irritation by acting as foreign bodies, and necessitate the dressing of the wound in order to shorten or otherwise adjust them.

Carbolized Catgut as a drain.—The use of carbolized catgut as a substitute, was proposed by Mr. Cheine; eight or twelve threads would effect the drainage of the wound through capillary action, and its absorption would prevent the necessity of dressing the wound, practically, however, it had objections; it was found that soon after introduction into the wound it swelled and softened, and became closely connected with neighboring tissues. Its rapid absorption was its main advantage, but the rapidity with which this was accomplished destroyed in a great measure its utility as it was difficult to presage whether in a given wound drainage might not be required for a longer period than a few days, beyond which it was useless. Its physical character precluded it from draining pus.

Horse Hair as a Drain.—Mr. White proposed horse hair as a drain on account of its cheapness, its adaptability, its resistance to absorption and its non-irritating properties. It is now very frequently used with the best results. A wisp of hair introduced into a wound is supposed to act by capillary action; it can do so in two ways, by the minute spaces existing between the individual hairs forming capillary tubes, and by the flow of the fluid along the outside of the hair. The finer the tube the higher will the fluid rise in it, consequently in this respect hair will be a better capillary drain than most sizes of catgut. All liquids do not rise to the same level in capillary tubes while some are actually depressed within them; serum and liquid blood rise within these tubes while pus does not do so to any great extent. For blood and serum therefore horse hair is an excellent drain, but for pus it is not reliable. For the drainage of pus something else is required than capillary drains.

Bone Drains.—Recently Neubauer has introduced what he calls "resorbent tubes," drilled out of horse and ox bones, and then decalcified and carbolised, their object being to act as drains and then to yield to absorption. In cases in which they were used they disappeared in from two to five days. These tubes disappeared too soon; they acted during the period that blood and serum required to be drained, and disappeared before pus was likely to be found. What was wanted was a tube which would remain in the tissues as a drain for eight or ten days and then become absorbed. This purpose is accomplished by chicken bones, which are easily prepared for use by a simple process; they are pliable and elastic, capable of retaining for some time their form under the weight of thick flaps. The tibiae make the longer, the femora the wider tubes. These tubes are always threaded with hair before they are introduced into fresh wounds; any kind of drainage tube introduced into a wound is apt to become blocked with blood clot; to obviate this it is threaded with hair, which sheds the blood and serum of the first few days, after which the hairs being no longer of use are removed leaving the drainage tube perfectly patent.

Antiseptics.—There are two methods whereby the evils of septicity may be avoided, to prevent the entrance of the germs of putrefaction, and to

render the soil unsuitable for their multiplication. The first and most important involves all that minute attention to detail in cleanliness and the use of germicides, which Mr. Lister has so thoroughly established; his antiseptic method or some modification of it is now generally employed wherever practicable; the method of its application is well known to most surgeons. The success of the treatment is generally admitted by those surgeons who have given it a fair trial, and many are only deterred from using it by the extra labor which it entails. But the second is scarcely less important; it is less important, because if the entrance of noxious germs be prevented, it would matter little what the nature of the soil might be. But germs creep in notwithstanding all precautions, and it is of great moment that they should find conditions unsuitable for their multiplication; for example, the chances of a wound becoming septic are much greater in a diseased than in a healthy man, and it is certain that the results of septicity are much worse in the weakly than in the strong. This object of course involves the care of the patient's general condition; but the soil may also be rendered unsuitable for germination by means applied locally. Dryness is highly conducive to safe and rapid healing, moist warmth favors all forms of decomposition and promotes exudation; careful arrest of hemorrhage and a covering at once dry and permeable are therefore strongly indicated. There is no doubt great difficulty experienced by the general practitioner in attempting to carry out the minute details of the Lister dressing; where practicable, however, its efficiency is too well established to be gainsaid. There are, however, several modifications of it which answer the purpose and are much less expensive, thus removing one of the objections to its use. Professor Es-march has achieved great success, as is well known, under the system of infrequent antiseptic dressing, it being a by no means uncommon event for the first application to be left undisturbed for a month; in place of antiseptic gauze, he uses, large pads of carbolized jute, which readily absorb the discharges, with carbolised varnish paper over all and starched gauze bandages; protective is not used. Neubauer's bone drainage tubes are extensively used, and indeed without some such self-removing drain, the dressings could not in resection and other cases, be left untouched for so long a time as they

are with its help. The tube is kept in its place by being simply transfixed at its outer end with a common safety-pin, and when after two or three weeks the first dressings are removed, these pins are usually all that remains to show where the decalcified bone tube has been. The solution of carbolic acid used for the spray, is of the strength of one to forty, and it is not thought necessary to have it playing immediately on the wound, but this latter is washed out frequently with carbolic acid lotion.

Dr. Little, Professor of Clinical Surgery in the University of the City of New York, has adopted and extensively used a modification of the Lister dressing, especially applicable to the treatment of small wounds, in which he has met with gratifying success; it is easily applied and admirable in its results. He says: "I have been for several years surgeon to a large factory in this city in which three thousand hands are employed, and where injuries by machinery are very frequent. These injuries are chiefly of the hands and fingers, caused by being caught in cog-wheels and other parts of the machinery. In many cases the fingers are torn off, tendons are pulled from their sheaths, joints are opened, and the hands are often severely crushed and lacerated. In all of these cases I have for the past six years been using the following simple antiseptic dressing: Having put the parts in a condition for dressing, I wash the wound in a carbolic solution (1 to 20), I then cover the parts with a thick layer of borated cotton, and then snugly and evenly apply a simple gauze bandage. These thin bandages distribute the pressure more evenly over the cotton, and are more easily saturated with fluids than those made with unbleached muslin. The patient is instructed to keep the outside of the dressing wet with a solution of carbolic acid (1 to 100). The dressing may be left undisturbed for several days unless there is pain, rise of temperature or discharge through the dressings; these conditions are always to be considered indications for redressing. My experience with this dressing covers a period of six years, during which time I have treated nearly three hundred cases of open wounds—*not one of the number* has been followed by inflammatory symptoms. Extensive lacerated wounds and dead tissue has sloughed away without giving rise to any of the so-called symptoms of inflammation; neither pain, redness, heat,

swelling nor constitutional disturbance has resulted. No counter openings have been necessary. These results are the more remarkable from the fact that many of these patients were in an unhealthy condition, some suffering from anemia, some from cardiac disease, phthisis and the like. The value of cotton wool as an antiseptic dressing is, I think, not fully appreciated by the profession. M. Guérin, Paris, in 1872, and since then Mr. Gamgee, of Birmingham, have called attention to its great value. Used in the way I have indicated it seems to me to be as perfect an antiseptic dressing as the gauze and other materials of Lister, while at the same time it is free from all objections that pertain to the latter, and which hinder their use by the general practitioner. If applied in sufficient quantities around an open wound, it protects it thoroughly from the floating matter of the air which is supposed to be the real inciter of suppuration. It is the best germ filter known to us. Tyndall, whose experiments were carefully made, found that while filtering the air and endeavoring to get it perfectly pure, atmospheric dust which would readily pass through sulphuric acid and a strong solution of caustic potash, was completely stopped by ordinary cotton wool. I would state in conclusion that my experience thus far seems to shew that this dressing, so easy of application, is as thoroughly antiseptic as Lister's appliances, and that it has the advantage of doing away with the necessity of using costly "protective oil silk, macintosh cloth, carbolised gauze, etc., and gives us a dressing that can be used by any one, under any circumstances, be it in city or country. The borated cotton is easily kept for months unchanged. The fact that the dressings need not be done oftener than once in several days will especially commend it to the country physician." The success of this procedure in the treatment of large wounds after accident or amputation, will increase its importance and materially extend its field of usefulness.

UTERINE TENTS AND THEIR USES.*

BY J. G. ATKINSON, M.D., ETC., OAK HILL, N. B.

Mr. President and Gentlemen,—The idea of dilating the os uteri by means of compressed materials has long been recognized. Aëtius, an early

medical writer, describes this treatment. The venerable Paré practised it. Dr. Macintosh, of recent times, now deceased, was a great advocate of its use, and Dr. Simpson, of Edinburgh, and Drs. Oldham and Barnes, of London, accepted it. Leading gynecologists now universally regard this measure as of infinite service in certain cases. Various dilating materials have been used. Tents were formerly made of ivory, the bony matter having been taken out of it by means of hydrochloric acid. A tent made in this manner, when placed in the cervix, would swell to double its former size. But the favorite agents of to-day are the sponge, laminaria and tupelo tents.

Since its first introduction as a uterine dilator, the sponge tent has undergone numerous modifications and improvements. When first manufactured, a flat piece of sponge "was saturated with wax, and pressed flat between pieces of marble." This was a very inefficient instrument, as it only expanded in one direction. Dr. Sims, in his work on Uterine Surgery, was the first to suggest the conical form of sponge tents. Saturating a conical piece of sponge with a strong solution of gum arabic, and passing a wire stylet through it from centre of base to apex, he wound it tightly with a strong cord, and hung it up to dry, after which the cord and stylet were removed and the tent smoothed with sand-paper. Subsequently it was found that if the cord was wound around the sponge sufficiently tight to give the tent good expanding force, the stylet was removed with considerable difficulty. This inconvenience induced Dr. Albert H. Smith, of Philadelphia, to devise a new method of preparing the tent. Taking a cylindrical piece of sponge saturated with water only, and without employing a central stylet, he wound it with a piece of fishing-line to which a six-pound weight was attached. This thoroughly compressed the tent to which the form was given by the fingers during the rolling process. The common method of preparing sponge tents consists in cutting conical pieces of sponge from two to three inches long with bases varying from the width of a little finger to that of an egg. Each piece is saturated with mucilage of gum arabic, a wire is then passed through its centre, when it is wound tightly from apex to base with a strong cord. The stylet is then taken out and the tent hung up to dry, after which the cord is removed, and another is either passed through

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the sponge and sewed fast to its apex, or simply passed through the tent at a short distance from the base. None but clean, fine, strong material should be used in preparing tents. Those made of coarse rotten material are liable to break during extraction, leaving pieces in the uterine cavity, which may lead to serious results. A tent should be made from a cylindrical piece of material, and when finished, should be of uniform size from end to end. The apex of a conical tent does not have sufficient dilating power over the internal os. The conical tent has frequently been withdrawn with its apex unexpanded, while the cervical cavity and external os were dilated by the base of the tent. If a conical tent is used the apex should be cut off. Experience favors the use of the straight in preference to the curved tent, as the former requires less force for insertion, and the uterus is easily straightened before introduction, by means of a soft metal dilator.

In regard to the qualities and action of tents, the sponge tent expands quickly but dilates slowly. This being the case, it is not liable to slip from the uterus before extraction. It is porous, and permits escape to the menstrual and other discharges, and on this account may be used during the menstrual period in the treatment of sterility. It "has a disintegrating power over morbid surfaces," and is an efficient means of treatment in many cases of intra-uterine disease. The sea-tangle tent has the advantage over the sponge in that it allows no animal matter to decompose, producing fetor and irritation; it has greater dilating power than the sponge tent, and causes more pain than the latter; it is liable to slip from the uterus after it is fully expanded. It does not possess the action of sponge over "morbid surfaces." A laminaria tent the size of a No. 8 bougie will sufficiently expand the canal to admit the finger. Tupelo tents are generally of uniform size from end to end; they are smooth and easily introduced; they have good dilating power, and cause little pain; they do not imbibe much of the discharges, nor sink into the uterine tissues. If large enough to be of any benefit, they will not allow discharges to pass through or beside them, and therefore not useful during menstruation.

In preparing the tent for insertion, Prof. Mundé dips it first into a jar of liquefied carbolic acid, and passes it rapidly into a jar of vaseline, and after-

ward passes it rapidly into the uterus. Dr. A. H. Smith coats the tent with soap or cocoa butter, into which finely powdered salicylic acid is thoroughly rubbed. In this day of antiseptic precautions, carbolized tents are prepared for immediate use. These only need lubricating. In introducing the tents many use a properly constructed tent carrier consisting of a handle into which is fastened a stylet carrying a spiral for disengaging the tent after it is forced home. A uterine probe or piece of stiff wire carrying a catheter, makes a good temporary instrument; some employ a peculiar forceps made especially for inserting tents; these hold the tent firmly and enable the operator to pass it rapidly to its position; others use no instrument of any kind, but simply wind the string hanging from base of the tent around the index finger of right hand, and insert adjacent thumb nail into base of tent; they then pass the first and second fingers of the left hand behind the cervix, and inserting the apex of tent into the os uteri, the left hand is transferred to the abdomen, counter-pressure made, and the tent forced home. The most convenient method consists in the use of the bivalve speculum, soft-metal dilator, and tent carrier or forceps. The speculum exposes and holds the parts steadily to view, the dilator prepares the part for the reception of the tent, and the carrier or forceps forces it home while pressure is made over the fundus. If the insertion of a tent is immediately followed by severe pain, it should be withdrawn one quarter inch, as pain may be caused by the pressure of tent on the fundus. In regard to the position of the patient, this is a matter of choice. Prof. Mundé places his patient in Sims' position, seizes the cervix with a tenaculum, and inserts the tent with strong forceps. Dr. A. H. Smith prefers the position on the back, asserting in defence of this position, that the relation of the parts is more natural, and that the uterus is more easily straightened by counter pressure over the fundus, making insertion easier.

With reference to the length of time a tent should remain in the cavity, opinions differ widely. Dr. Barnes states that a tent should be introduced in the evening and removed early on the following morning, or introduced in the morning and removed in the evening, claiming that this method "combines the least distress to the patient with the greatest convenience to the surgeon." One

eminent writer asserts that a "tent ought never to be left in the uterus more than twelve or at longest twenty-four hours." Prof Mundé states that he always removes a tent at the end of twenty-four hours; that "he always dreads some bad result, but has been fortunate so far, and has not seen any." Many eminent gynecologists allow the tent to remain in the uterine canal for forty-eight or seventy-two hours, for which plan the following reasons are given:—At the end of twenty-four hours the sponge is buried in the uterine walls, which firmly grasp the tent, and if it is now extracted it will drag away portions of uterine tissue, causing hemorrhage, and leaving a raw absorbing surface. At the end of forty-eight or seventy-two hours, the tent is easily withdrawn without removing tissue, and no bleeding follows. Again, at the end of twenty-four hours the uterus still retains its contractile power, so that if a finger or instrument be introduced either for diagnosis or treatment, the irritation thus produced causes the uterus to rapidly contract, rendering medical or surgical procedure unavailing. At the end of forty-eight or seventy-two hours the uterus becomes paralyzed, the pain has ceased, and the local irritability is so reduced that a satisfactory diagnosis and treatment may be carried out. From all this it will be seen that the end to be attained must guide in the method of application. If only simple dilatation is required the tupelo or laminaria tent will effect it in twenty-four hours, and one of these tents is to be preferred; but if the dilatation is required to facilitate diagnosis and treatment, then the sponge tent will answer the most ends and best purposes, and should remain in the uterine cavity at least forty-eight hours, unless symptoms should arise compelling removal. The patient should remain in bed from the time of insertion of tent until two days after its removal. Hot water injections after insertion quickly expand and fix the tent; some lightly plug the vagina with lint soaked in carbolic acid oil. Antiseptic solution injected into the vagina every few hours is both proper and requisite; pain may be controlled by opium, or opium and belladonna suppositories introduced per rectum. After the removal of a tent, the uterine cavity should be washed out with a warm solution of salicylic acid or other suitable antiseptic fluid, the vagina to be washed out with the same during the stay in bed. In removing a tent, the operator

should push in slightly at first, then rotate the tent by means of forceps until it becomes perfectly loose; extraction should be made with a twisting motion in one direction.

There are dangers also attending dilatation of the cervix. Dilatation of the cervix may be affected in several ways, each of which presents a history of alarming, if not fatal symptoms. Among the evil consequences which have followed the use of uterine tents may be mentioned septicæmia, pelvic cellulitis, peritonitis and tetanus. Dr. Sims relates a number of such cases, some of which threatened a fatal issue. Dr. Aitken (*Edinburgh Journal*, 1870,) relates others, in one of which retro-uterine hæmatocele occurred. Beside these formidable results, we have various reflex nervous disturbances, either with or without danger. Dilatation of the cervix by incision offers no less danger. Bloodvessels enter the cervix just above the internal os penetrating deeply into its structure, and "venous canals are maintained as more or less rigid tubes." An incision a quarter of an inch deep is liable to divide these vessels, and as a first danger, alarming hemorrhage takes place; and as a second, from the gaping of divided veins, and the injury to the structures through which they run, pelvic inflammation and septicæmia result. Dilatation by incision, or by mechanical dilators other than uterine tents, offer no advantages over the latter, as all are frequently attended with but transitory results, for the isthmus may contract again, while incision is attended by greater danger than either. To avoid the danger of septicæmia, the strictest antiseptic precautions should be observed both in regard to the tent employed and in the treatment of the patient. Dr. Aitken claims that a tent should never be employed where there is any inflammation, and Dr. Barnes terms this "a proper caution." But this view has not been sanctioned by medical experience, as the employment of tents is the most successful treatment in chronic metritis and hyperplastic enlargement. Prof. Mundé states that, "It is a maxim that a sponge tent should never be introduced into a fresh wound," and it has been shown, elsewhere, that if a tent is removed twenty-four hours after its insertion, hemorrhage is the result, demonstrating that the tent has produced a fresh wound. Some contend, that these cases which terminated in a fatal issue were probably due to the insertion of

three successive tents at intervals of twenty-four hours. Pelvic cellulitis, peritonitis and tetanus may be expected in practising such a treatment. The employment of tents only at intervals of forty-eight hours is the safest and most efficient method for reasons already given. At a late meeting of the Philadelphia Obstetrical Society, the weight of medical testimony was given in favor of this method, and experience had seen no evil results following such a plan. Before leaving this point, attention is called to an incident which sometimes occurs at the internal os. This part yields to the dilating power with most difficulty. At this point, sometimes, a deep furrow or circular constriction is formed in the tent, while the uterine and cervical ends are freely expanded, and there is danger of the upper expanded portion becoming detached by the force of traction, to be left in the uterus, producing fetor and irritation. It is well to bear this fact in mind during extraction.

Diagnosis and treatment by means of tents.—Uterine tents are valuable aids to the surgeon, both as a means of diagnosis, and as an important therapeutic measure. In obscure intra-uterine disease the speculum, sound and other instruments have proved inadequate as a means of diagnosis without previous dilatation of the uterine canal. Having effected a thorough dilatation of the uterine cavity, the finger and the endoscope can survey the whole endometrium, making a rational diagnosis. Dilatation of the uterine canal, sometimes affords the only opportunity of pursuing an efficient treatment. Well authenticated instances are recorded in which uterine tents employed as a means of diagnosis, also resulted in an efficient means of cure. The surgeon suspecting the existence of some obscure morbid growth in the interior of the uterus, introduces a tent to facilitate exploration, and after withdrawing it is agreeably surprised to discover that the sponge has disintegrated the morbid product, so that it can be removed by the finger.

In cases of severe *hemorrhage* in the non-pregnant state, we are suspicious of intra-uterine disease. Here, the internal administration of astringents is often worse than useless, and we are compelled to employ other expedients for allaying the hemorrhage. In his work on "Medical and Surgical Diseases of Women," Dr. Barnes explicitly states in italicised words, "*in all cases of hemorrhage*

coming from the body of the uterus, obtain and maintain free patency of the cervical canal," and he adds, "in cases of abortion, of the hemorrhages of gestation, of intra-uterine polypi, of hypertrophy of the mucous membrane, of malignant disease of the interior of the uterus, to afford free escape to the hemorrhage, and free access to its source to control the bleeding is the first necessity." The uterine tent will answer both of these indications in that it expands the canal, allowing free escape to the hemorrhage, and permits the surgeon to have free access to its source to apply the appropriate remedies. But in answer to this mode of treatment, it may be urged that a catheter or other tubular instrument may be introduced into the uterus, and through it a styptic injected to control the hemorrhage. But this is frequently useless as well as dangerous treatment—useless, because the styptic may be lost upon the clots—dangerous, because the styptic fluid may be driven along the Fallopian tubes, producing alarming, sometimes fatal results. Again, it may be urged to employ a swab upon the end of a probe, and introduce this charged with the styptic. Here, too, this method is often fruitless, because the charged swab, irritating the cervix in its passage, causes a contraction of the canal, and cannot be introduced. Plugging the vagina with a tampon is a useful temporary expedient, but has the disadvantage that it does not in any way alter the condition in which the flow originated, and the hemorrhage sets in again after its removal. But all these means, if successful in checking the hemorrhage, will not remove the original cause. The sponge tent, possessing a disintegrating power over morbid surfaces, removes the cause of hemorrhage. In 1852, Dr. J. Henry Bennet, of London, plugged the os uteri instead of the vagina, and this method, in his hands, proved a successful treatment in obstinate cases of hemorrhage. The uterine tent is an excellent tampon for the purpose, and is an efficient means of controlling the flow. Filling up the entire cavity, it does not allow clots to form and degenerate into fibrinous masses. Again, Dr. Barnes asserts in effect, that preliminary dilatation of the cervix uteri, in many cases, is sufficient to arrest the hemorrhage. The uterine tent is a safe and efficient dilator fulfilling this indication also. The conclusion is therefore reached, that in the treatment of uterine hemorrhage, the tent acts as a

dilator which may remedy the condition, and remove the cause; a tampon which checks the flow, and last but not least, leaves the canal in such a condition, that more efficient treatment may be employed.

The induction of premature labor may be rapidly and safely produced by the use of uterine tents. The usual plan of attaining this end is to introduce tents into the os uteri, a larger one being inserted every few hours. This method produces little pain, brings on labor rapidly, preserves the membranes intact as long as possible, and favors the birth of a living child.

In the treatment of certain forms of sterility tents are also serviceable. The causes of sterility are too numerous to be explained in this short paper. It may exist in the male as well as the female. In the female it may be congenital or acquired, absolute and incurable, or relative and temporary. Two classes of causes may here be enumerated:

1. Those in which obstruction prevents the meeting of the ovum and spermatozoa.

2. Those in which the mucous membrane of the uterus does not afford a nidus for the ovum.

Those causes in which obstruction prevents the meeting of the ovum and spermatozoa form a number of distinct conditions which are not within the province of this paper to discuss. Attention must be confined to the consideration of conditions which are relieved by means of tents. Narrowing of the uterine canal at some point, whether congenital or acquired, is a frequent cause of sterility. Dr. Barnes says, "by far the most common associated condition, in my experience, are congenital narrowing of the os externum and retroflexion of the uterus." But the narrowing may be at the internal os, or along the whole or at any part of the canal. Some difference of opinion is expressed concerning the value of the different tents used as a relief of sterility. One gynecologist of large experience is of the opinion that the cases which have been relieved by sponge tents would have probably received the same benefit from the laminaria and tupelo tents; while another gynecologist, equally eminent in every respect, holds that no other means which can be employed will answer as well as the sponge tent. The tupelo and laminaria tents will expand the canal, but they will not allow the menstrual discharge to pass

through them unless perforated, and they are apt to slip from the canal after they have been expanded. The sponge is porous and allows the discharge to escape, and its surface being rough it will not slip from the cavity. The most successful practice consists in introducing a sponge tent into the uterine cavity just previous to a menstrual period and allowing it to remain until the flow has passed through it, when it is to be removed.

If tents are used between the periods, they prevent coition, cause a loss of epithelium, and the canal is likely to contract again either before or during the ensuing period. Authorities state that the uterus sheds the elements of its mucous membrane at every menstrual period. "Virchow" contends "that the detachment of the uterine mucous membrane during the menstrual period is more complete than is generally supposed, and that in normal menstrual blood, heaps of cells are often met with, which, by their structure, reveal their origin in the uterine glands." This being the case, a sponge tent used during the period would not interfere with the sexual act, nor cause extra loss of mucous tissue, and the mucous membrane would return to its natural condition before the period at which conception generally takes place. Those cases in which the uterine mucous membrane will not afford a nidus for the ovum, make up a numerous class. Chronic metritis, hypertrophy, ulceration, fungoid and other growths, as well as chronic disease of the mucous membrane itself, may be mentioned in this connection. The successful treatment in these cases consists in curing the patient's disease. The sponge tent answers the indications, as by its use we get rid of a morbid surface and stimulate the uterus to produce a healthy membrane, which will afford a nidus for the ovum.

The sponge tent is safe and effectual in destroying *intra-uterine granular growths*, owing to its disintegrating power over diseased surfaces. "The healthy tissue will contract again, but diseased structure will not contract, but will slough off, its vitality being destroyed." Dr. A. H. Smith reports that he has had cases of uterine disease resembling epithelioma, attended by profuse hemorrhage, which were cured by the use of sponge tents—(*New York Med. Jour.*, Nov. 1882, page 520). In chronic metritis and hyperplastic enlargement, the sponge tent is invaluable in the treatment. It has

a stimulant effect on the uterine parenchyma. Dr. Routh asserts that "the sponge tent itself suffices to cause absorption and diminution of volume of the uterus." Drs. A. H. Smith, P. F. Mundé and J. Cheston Morris unite in their testimonies as to the value of sponge tents in the treatment of hyperplasia. When the prolonged applications of iodine and acids have failed in curing the disease, the repeated use of sponge tents will reduce the bulk of the enlarged organ and, perhaps, effect a cure. In the treatment of chronic metritis, the tent acts in imitation of an abortion—first expansion, then contraction, assisted by the internal administration of ergot, will cure chronic metritis and enlargement.

In *dysmenorrhœa*, caused either by stenosis or morbid growth of intra-uterine membrane, uterine tents afford excellent means of cure. In *dysmenorrhœa* resulting from uncomplicated stenosis, the tupelo or laminaria tent should be preferred, as they dilate strongly and efficiently without lacerating the uterine walls. The tupelo tent causes the least pain. But in *dysmenorrhœa* complicated with diseased surface, the sponge tent answers the indications. The tent is employed just previously to a menstrual period, in the hope that the desired dilatation will be effected, or diseased surface removed, and the patient thereafter relieved.

We give the following cases to illustrate the treatment of morbid uterine conditions by means of tents :

CASE I.—Hæmorrhage.—A lady had been bleeding profusely at every period for three years. Supposing a polypus to be the cause of trouble, a sponge tent was inserted to secure dilatation. On removing the tent no polypus was detected, and more tents were passed to fundus. On withdrawing these it was found that the tents had broken up fungoid growths, which were removed. The patient remained well after the uterus contracted.

CASE II.—Sterility, stenosis.—A lady, being sterile and suffering from *dysmenorrhœa* caused by stenosis, had a sponge tent introduced just previous to a menstrual period. The flow came on two days afterwards, "entirely without pain for the first time in the patient's experience ; the flow escaped through the sponge, and the latter was then removed. Conception occurred before the next menstrual period."

CASE III.—Fungoid growth.—A patient was

sent from Boston to Philadelphia for diagnosis only. The uterus was dilated with the largest sponge tent passed to the fundus. After removing tent the finger detected fungosities on anterior wall. The sponge had disintegrated the growths, and the means of exploration, resulted in a cure.

CASE. IV.—Chronic Metritis, Hyperplastic enlargement.—This case had been treated with local applications of iodine, nitric acid etc. without any perceptible effect for considerable length of time, "when the repeated use of sponge tents resulted in a complete restoration" of the organ "to its natural size."

CASE V.—Polypus.—This was a case of polypoid pedunculated growth. The uterus was dilated with a bougie, and afterwards with sponge tents. "The finger found a pedunculated growth as large as a hen's egg, but the tent had disintegrated it and it could be removed by the finger without instrumental aid.

CASE VI.—Dysmenorrhœa, Convulsions.—This patient had suffered severe pain attended by convulsions at every menstrual period for several years. She had exhausted all the medicines intended for the relief of such cases without benefit. An examination showed that the os uteri formed a small circular opening, which would only admit a No. 5 catheter, and the same entered the cervical canal about one and a half inches. A small uterine probe passed with some difficulty and discovered a firm growth creaking under pressure, situated on anterior wall of cavity at the site of internal os. Just previous to a menstrual period a small sponge tent was introduced. The flow came on next day and passed through the tent without pain. On the second day uterine contractions expelled the sponge, together with pieces of membrane resembling cartilage. Just before next period a Simpson's sound passed easily into the uterine cavity two and a quarter inches, and met with none of the dense tissue before referred to. The patient continued afterwards to menstruate without pain or convulsions.

Correspondence.

To the Editor of the Canada Lancet.

SIR,—I find in looking over the report of the meeting of the Ontario Medical Council, in the address of the retiring president, Dr. Bray, a very

good suggestion, viz., "That the profession should agitate for a uniform bill for all the provinces, whereby the standard would be the same, so that a man having passed the Council of one province could register in another by paying merely the fee."

As the act reads, in British Columbia a graduate of the Ontario Medical Council would not be permitted to register in this province. He must be a graduate of a University in good standing; hence you see the injustice to those who only have passed the Council in Ontario, and are debarred from practising by the act. The provinces are in such alliance now that the laws of one should accord with the others. The inconvenience to graduates of the Council who may wish to go to the other provinces to practise is very great.

At next session of the local Parliament in this province, steps may be taken to obtain a new Medical Act, but if a Dominion Act is contemplated it would be useless to do so. I for one would like to see a uniform Medical Act for the Dominion; it would place the Medical profession on a better footing and keep the standard up in the younger provinces as well as in the older, and at the same time not interfere with the graduates of the provincial institutions. Hoping you will give this your consideration.

I remain, yours, etc.,

M. B.

Victoria, B. C., Aug. 6, '83.

Reports of Societies.

NEW BRUNSWICK MEDICAL SOCIETY.

The third annual meeting of the above named society was held in St. John, N. B., on the 17th of July, Dr. S. Z. Earle, president, in the chair; Dr. G. M. Duncan, secretary. There was a full attendance of members present.

After routine, Dr. Allison read the Report of the By-law Committee, which was adopted after certain amendments.

Dr. Inches, the treasurer, presented his report, which was adopted.

Dr. Coleman moved that the president appoint a committee to arrange a scale of fees for the N. B. Med. Soc'y. Drs. Coleman, Brown, Wilson, Jas. Christie, and Moore were appointed on the committee.

Dr. Coleman moved, seconded by Dr. Travers, that a committee be appointed to consider what means may be taken by the Society to assist the Council to induce physicians to register and to prevent unqualified persons from practising. Drs. Coleman, Allison, McFarlane, Duncan, D. E. Berryman, G. P. Caldwell, and Daniel were appointed that committee.

Dr. Patterson then read the report of the committee appointed to revise and amend the N. B. Med. Act, 1881. The report was, on motion of Dr. Inches, received and laid on the table.

The president, Dr. Earle, then delivered the annual address, taking for his subject "General Principles of Diet."

Election of officers was then proceeded with and the following members were elected:—Dr. Vail, president; Dr. Walker, 1st vice president; Dr. Patterson, 2nd vice-president; Dr. G. M. Duncan, general secretary; Dr. Coleman, corresponding secretary; Dr. Nevers, treasurer; Drs. Daniel, Allison and Berryman, trustees.

Dr. Bayard, president of the Council of Physicians and Surgeons of New Brunswick, then read a report which was, on motion of Dr. Daniel, seconded by Dr. Patterson, received and ordered to be entered on the minutes.

Dr. Currie then read a "Report of Cases in Practice": 1st. A case of Lupus Exedens of about nine years' standing, associated with Lupus Erythematodes; 2nd. Nævus of the Face treated by Electrolysis.

A conversazione was held in the evening. An excellent display of instruments was made by Drs. John and D. E. Berryman, Dr. Coleman, and others. Refreshments were served by a committee of St. John ladies and a pleasant time spent.

SECOND DAY.

The Association met at 9.30 a.m., Dr. Earle, president, in the chair.

Dr. J. G. Atkinson, Oakhill, read a paper on "Uterine Tents and their Uses," which is published in the present issue.

Dr. Patterson moved, seconded by Dr. Brown, that five minutes be allowed each member for discussion. Carried.

Dr. Musgrove highly appreciated Dr. Atkinson's paper.

Dr. Patterson said it was officiousness to use tents in many uterine diseases, e.g., in sub-involu-

tion, potash salts with ergot were sufficient. It was highly objectionable to give a woman an idea she had uterine disease.

Dr. Brown related a case of "Fishbone in the Rectum." Twelve years before the patient had, while laughing, swallowed a mouthful of chowder without mastication. For a month there was pain in the stomach; removed then entirely after a glass of brandy; no further trouble till day of removal when there was the most excruciating pain calling for examination, which resulted in its discovery and removal.

Dr. Gaynor, Debec, read a paper on "Chloroform as an Anæsthetic—its Physiological Action and Therapeutic Value."

Dr. Coleman said that in his experience death came from the heart, and he failed to understand why it was recommended to study the breathing and pay no attention to the pulse. Ether is safer, because a cardiac stimulant.

Dr. Musgrove said in regard to stimulants administered before using chloroform, it added to the danger, and was now condemned.

Dr. Atherton said that as regards safety, *that* depended on purity. He believed death came from stoppage of respiration, which occurred before the pulse stopped. He recited a case of his own in which tracheotomy was performed and the patient's breathing was resumed. He deprecated the use of brandy before chloroform inhalation. In regard to food given before, better given three hours before than six.

Dr. McFarlane believed that the heart and lungs stopped simultaneously.

Dr. Inches pointed out that Dr. Atherton did not watch the pulse in the case related. He thought the pulse sounded the warning.

Dr. Gray said that in his experience the pulse slows first, and runs up when administration stopped. Careless administration had something to do with fatality.

Dr. Moore did not attend to either breathing or pulse particularly, but watched all the conditions and gave no undue importance to either. Extraction of teeth under either ether or chloroform is a reprehensible practice. He recited a case showing danger of food a short while before. Had assumed no food taken; vomiting ensued and danger of suffocation for some time.

Dr. Currie endorsed Dr. Moore's statements.

Dr. Brown had occasion to take chloroform many times, no difficulty till lately. Glass of brandy taken slowly overcame this. Stomach should be empty, or at least no food for five hours before.

Dr. Nevers had misgivings in regard to ether. At its first administration in Philadelphia death

had occurred. Since then he had always given chloroform. Case given in which chloroform was used in extracting a tooth. Pulse was all right. Respiration stopped and there was considerable trouble to resuscitate.

Dr. Coulthard, in re heart v. pulse, said: In confinements there is little danger from chloroform. Why is this? Diaphragm is called into action to aid expulsive efforts of abdominal muscles, and respiration goes on regularly, and difficulty he therefore thought was from failure of respiration and not of heart.

Dr. Caldwell had experience as a dentist in giving both ether and chloroform, as well as gas. Preferred ether or chloroform when a large number of teeth had to be extracted. Effects more lasting than gas which was suited for short operations only. Does age influence? He thought chloroform less safe than ether in the aged, and vice versa.

Dr. Jonah related a case of Dr. Pancoast, of Philadelphia. Ether was being administered, those doing so were paying no attention to their duty. Dr. Pancoast noticed a cyanosed condition, sprang to his patient, and after much vigorous effort, danger was averted. May not death from chloroform in some instances be due to some idiosyncrasy? In some other cases drugs disagree, e.g., tobacco. May not ether and chloroform disagree with particular patients, irrespective of purity or careful administration?

Dr. Walker spoke of death in the dentist's chair as due to the chair. Position should be horizontal. In regard to food before using anæsthetics, he related two cases of danger from suffocation. His practice was to operate early in the morning, before food could be taken.

In the afternoon session, Dr. Jonah read a paper on "Hydrocele," treated by carbolic acid injections. (See editorial note).

Dr. Allison moved "that the Council be requested to furnish each member of the society annually with a copy of the current Register, by such means as may be most convenient." Carried.

A motion was adopted, asking the president to name a committee of three, with permission to add to their number, to consider and report, at next annual meeting of the society, upon the advisability and practicability of establishing a quarterly medical journal. Drs. Steeves, Bayard and Atherton were appointed on the committee.

Dr. Currie, Registrar of the Council, said that the Council requested those who know of unregistered, or illegal practitioners, to report them to him, when action would be taken.

Dr. March then read a paper on "Plaster." Dr. Allison agreed with Dr. March, but thought that in some instances starch or dextrine suited

better, *e.g.*, fracture of limbs, where its lightness was preferable. Dr. Hamilton said that felt was even better than either.

Dr. G. P. Caldwell read a paper on "Fracture of Jaw" with apparatus.

The following papers were then, for lack of time, read by title:—"Hip-joint Disease"—Dr. M. C. Atkinson, Bristol. "Cases of Puerperal Septicæmia"—Dr. J. S. Benson, Chatham. "Diphtheria"—Dr. E. Cameron, Grand Manan. "Excision of Tongue"—Dr. G. M. Duncan, Bathurst. "Cases"—Dr. John Brady, Barnesville. "Tracheotomy"—Dr. H. H. Hanson, Andover. "Puerperal Septicæmia"—Dr. D. R. Moore, Sackville. "Pneumonia"—Dr. J. N. Smith, Hampton. "Treatment of Post-partum Hæmorrhage"—Dr. G. A. Hetherington, St. John. "Conservative Surgery in Compound Fractures"—Dr. McFarlane, Fairville. "Meningitis"—Dr. T. Walker, St. John. "Surgical Cases"—Dr. Atherton, Fredericton. "Venesection"—Dr. T. W. Musgrove, Carleton.

Dr. Coleman then read the report from the Committee on the Tariff of Fees. The report was adopted, except fee for post-mortem, which was made \$20. Copies were ordered to be printed and distributed to members.

The meeting then adjourned to meet in St. John, on the 3rd Tuesday in July, 1884.

ONTARIO BOARD OF HEALTH.

The Board met August 14th; members present, Drs. Oldright, Covernton, Cassidy, Rae, Yeomans, Bryce, and Prof. Galbraith.

After routine and the reading of communications, the Secretary read a report of the work during the past quarter, consisting of communications concerning the action of School Boards in cases of contagious diseases, as scarlatina in Perth school, diphtheria near Grimsby, diarrhoea in Cannington, etc.; also respecting epidemics, as small-pox near Claremont, diphtheria at Dickinson's Landing, typhoid at Niagara Falls;—nuisances, as a fat-rendering establishment at Doncaster and Richmond Hill; slaughter houses at Wales; liquid refuse from cheese factory at Easten's Corners; sawdust deposit at Parry Sound, etc.; excretal pollution of stream at Thorndale, etc.; jurisdiction and duties of local Boards of Health in Morrisburg, Markham, Parry Sound, Port Dalhousie, etc.

August 15th. The Board met at 10 a.m. Dr. Covernton read a report on the "Adulteration of Milk," which was adopted and ordered to be printed in the next Annual Report. He also read the translation of a paper read at the Geneva Congress in 1882.

Dr. Yeomans made a verbal Report of the Committee on "School Hygiene," and was requested to make a final report at next meeting of the Board, with a view to making certain recommendations to the Minister of Education, and that circulars be issued, asking for information from the various schools in the Province, for the use of the Committee in preparing the report.

The report of the Committee on Epidemics was read by Dr. Covernton, and adopted. The matter of publication of a pamphlet on Cholera was next considered in committee of the whole, and adopted.

The chairman then read a report concerning the steps which had been taken by the Committee of Markets and Health to improve the sanitary condition of Toronto, which was referred to the Committee on the disposal of sewage.

The following motion was also carried:—"The Board having learned that garbage—*i. e.*, street sweepings and other offensive materials—are being removed from the city to the Island opposite for the purpose of making soil, would earnestly recommend to the proper authorities that, previous to removal, these materials should be efficiently deodorized and disinfected."

On motion, the communication from Dr. McInnis, of Vittoria, was referred to the Committee on Accidents, and the Secretary was instructed to thank him for the interest manifested by him in the matter of preventing accidents from steam threshers.

On motion, the Board recommended to the Committee on Ventilation the consideration of some means by which the smoke nuisance at present complained of in Toronto may be removed or mitigated.

A communication was received from Dr. Essa Hunt, asking the chairman to attend officially the American Public Health Association at Detroit, on the 13th November. On motion, the Chairman and Secretary were requested to attend.

A communication was also received from F. N. Boxer, Esq., regarding the proposed organization of the Canadian Sanitary Association. The Chairman and Dr. Yeomans were appointed to attend its first meeting, to be held at Kingston in September next.

It was then moved that the next Sanitary Association be held in London in November next, should

the medical men and municipal authorities of that city deem it desirable.

On motion, it was also decided that a Sanitary Convention be held in Ottawa during the next session of the House.

Dr. Rae then presented a partial report of the Committee on Poisons, which was referred to the Committee on Publication. The report of the Finance Committee was adopted, as also that of the Special Committee appointed to visit London in connection with the recent floods. Certain insanitary conditions in Mount Forest, owing to defective drainage, were referred to the Committee on Sewage. The Secretary was requested to investigate the causes of the extensive prevalence of malaria in the district lying along the Grand River, and was authorized to employ such help as he may deem necessary.

A committee was appointed to have an isolation tent hospital constructed according to approved plans, to be exhibited at the Toronto Industrial and other exhibitions, and that sanitary apparatus be placed on exhibition therein.

Ten thousand copies of the next annual report were ordered to be printed for distribution, after which the Board adjourned.

MICHIGAN STATE BOARD OF HEALTH.

The regular quarterly meeting of the Michigan State Board of Health was held at Lansing on July 10th. The Secretary read his report of work during the last quarter, which shewed that a successful sanitary convention had been carried on at Reed City, and arrangements had been made for a convention at Muskegon, August 23rd and 24th; that considerable correspondence had been had concerning the examination of plans for proposed buildings at various State Institutions; that the report for 1882 had been distributed to various societies, libraries, etc.; that the weekly bulletin of health in Michigan had been regularly prepared and issued; that returns of the names and addresses of about 1,200 health officers had been received and filed; that a circular relative to the danger to be anticipated from small-pox, and one relative to the reporting of contagious diseases, with appropriate blanks, had been devised and distributed to all local boards of health; that the article entitled "Disease in Michigan, in 1882," had been compiled; that the accumulated letters

of the office for the years 1873-71, had been arranged and bound; that the compilation of the articles on "Meteorology in Michigan in 1882," and on "Weekly Reports of Disease in 1882," was well in hand; that circular 55, relative to the work of health officers, had been revised to conform to the new legislation of 1883, and, if approved by the Board, was ready for publication.

The Secretary read a resumé of the recent work of other State Boards of Health.

The Board then proceeded to examine plans for the proposed public buildings, under the law which requires all plans for State buildings to be submitted to the State Board of Charities, and to the State Board of Health. Plans were examined in detail, as follows: For wings to the present School for the Blind, at Lansing; for a proposed hospital at the Michigan Asylum for the Insane, at Kalamazoo; for a cottage hospital for the State Public School at Coldwater; and for a main building for the State Industrial School for girls at Adrian. Record was made of propositions which were approved, and several recommendations.

Dr. Avery reported a visit to Fremont, Newaygo Co., to examine into a nuisance caused by an extensive tannery, where five hundred tons of hides are annually tanned. He had made recommendations which in his opinion would abate the nuisance, and it had been promised that his recommendations should be complied with.

On motion of Dr. Lyster, the State Board's Committee on Buildings, including ventilation, etc., was requested to prepare a report on the best plans and methods of construction of hospitals suitable for the various State Institutions.

HURON MEDICAL ASSOCIATION.

A meeting of the above Association was held in Clinton, July 3rd, Dr. Hurlburt the president in the chair.

Dr. Sloan, of Blyth, showed a case of gunshot wound, caused by a 32-calibre revolver conical ball, at a distance of eight feet. The ball entered half an inch below the ensiform cartilage. Recovery perfect. Treatment by complete rest in horizontal position, bowels confined by opium for several days, urine removed by catheter, very little liquid given at a time, antiseptic treatment locally. No discharge from wound, which healed on the 28th day. He also showed a case of tumor in the

region of the liver. Aspiration was recommended by the members with a view to diagnosis.

Dr. Worthington, of Clinton, exhibited a case of Emphysema of the Lung, and read a report of a case of Exophthalmic Goitre, accompanied by Polyuria also.

Dr. Hurlburt showed a case of Synovitis, with recovery. The patient had been kicked by a horse nearly a year ago. Severe synovitis followed, confining him to the house for months; can now walk with the aid of a stick or cane.

Selected Articles.

PULSATING TUMORS OF THE HAND.— ROBERTS.

Traumatic aneurism occurs after wounds of the arteries of the palm with comparative frequency; but such a pathological condition of the fingers is very unusual. Martin, however, records 17 cases of traumatic aneurism in 72 instances of wounds of the arteries of the palm. The only case of the kind connected with the fingers, of which I am cognizant, is that reported by Annandale. His patient had a small pulsating tumor, with a distinct thrill, on the ulnar side of the ring finger, following a punctured wound made with a sharp hook. The case passed from observation, uncured, after some weeks' treatment by pressure; whether the pressure was applied to the tumor or to the arteries of the wrist the author does not distinctly state. Spontaneous aneurism of the palmar or digital arteries is exceedingly rare, and pulsating tumors connected with these vessels are not common. It is on account of the infrequency of such conditions that I record the following cases:—

MULTIPLE ANEURISMS OF THE SECOND PALMAR INTEROSSEOUS ARTERY.

This case was reported and the specimen exhibited, at a meeting of the College of Physicians of Philadelphia, in May, 1882. I therefore epitomize the history. The boy, aged sixteen years, from his earliest childhood had had a small elongated tumor upon the *dorsal* surface of the first phalanx of the left ring-finger, while in the *palm*, at the junction of the bases of the middle and ring-fingers, was a larger swelling. These were considered masses of dilated veins, as they had a spongy feel, and at times showed a bluish color. There was no very definite connecting band of swelling between the dorsal and palmar enlargements. About two months or less before I saw him the growths seemed to enlarge, and became accom-

panied by considerable pain, so that Dr. C. H. Thomas advised the use of a compress in the palm and a bandage around the finger. This the boy wore at nights, and usually from Saturday to Monday morning, when he was not required to work. Recently there had been noticed pulsation in the palmar tumor, and a lobulated feel, and Dr. Thomas feared that an arterial aneurism existed. When I examined the boy I found on the back of the third finger a hard, fibrous-like tumor, as large as a watermelon-seed, with the long diameter corresponding to the length of the phalanx. In the palm was an illy-defined swelling, covered with skin thickened and stained by labor, very sensitive to pressure, and occupying about the area of a silver half-dollar. No swelling was evident connecting the two tumors. On the ulnar side of the palmar mass moderately distinct pulsation could be felt, which quickly stopped when the radial artery was compressed at the wrist, but merely decreased in force when the ulnar was pressed upon with the finger. No pulsation was felt in the dorsal tumor. The boy had severe pain even when no pressure was made upon the growth in the palm. I considered the growth an arterial angioma connected with the second interosseous branch of the deep palmar arch; but determined to dissect it out, whether an angioma or an aneurism. Hence, after applying the elastic bandage and tourniquet to the limb, I made an incision and excised the palmar tumor and the nodule on the back of the finger, which were apparently connected by some fibres or small vessels. The tumor from the palm consisted of three lobules of rather unequal size, arranged somewhat as a trefoil. The largest one of them, when punctured, allowed the escape of soft clot. This sac was about one-half an inch in diameter. The three sacs seemed to be separate, because the head of a pin introduced into one did not pass into the others. The two smaller sacs or lobules were hard, as if the clot was old. One was laid open, and showed a white centre or nucleus, of cartilaginous consistence, surrounded by a layer of red clot. On the surface of this three-lobed tumor ran a nerve, which probably was the seat of pain from pressure, and parallel to it a small artery. The tumor from the back of the finger was hard, and on section showed an irregularly colored red surface. I believe the palmar tumors, therefore, to be small sacculated aneurisms evidently allied to the condition called *cirsoid aneurism*. The one on the back of the finger and the two smaller lobules in the palm were undergoing cure by coagulation, induced in the dorsal one, undoubtedly, by the pressure from the bandage used at intervals during six weeks or two months previous to the operation.* If the diagnosis had been more certain as to aneurism, digital compression of the

*This paragraph was written before the microscopic examination was made.

radial and ulnar arteries, or the use of an Esmarch elastic bandage to the forearm, would have been proper treatment before excision was attempted; but it would, I believe, have been unsuccessful. The microscopic examination of the nodule from the dorsal surface of the finger was made by Dr. Frederick P. Henry, and is as follows:—The tumor is a cavernous angioma, in which the vessels vary greatly in diameter. The smallest are no larger than an ordinary capillary, while the largest more than fill the entire field of a quarter-inch objective. Their walls are so thin that many of them might be mistaken for adipose tissue, were it not that they include blood cells. Considerable hæmatoïdine, mostly in granular form, is seen in the intercellular connective tissue." I have just seen this patient, who now, a year after operation, presents a tough cicatrix in the palm, which very slightly restricts full extension of the first phalanx of the finger. The second case was treated by me a few weeks ago, before my clinical class at the Philadelphia Polyclinic and College for Graduates in Medicine. I believe the tumor to be a sacculated or cirroid aneurism, similar to that just described, but found it, after excision, to be an arterial angioma.

ARTERIAL ANGEIOMA OF ONE OF THE DIGITAL ARTERIES.

The history, as taken from the notes of the College by my Registrar, Mr. Harry A. Stout, gives the following facts. The woman, aged 59 years, for ten years had had a small tumor, the size of a grain of canary seed, on the palmar and lateral aspect of the ulnar side of the right middle finger. It was the seat of no pain until a year or so ago; since that time occasional severe shooting pains, lasting from five to ten minutes, have been experienced, and have compelled her to cry out, from the intensity of the suffering. She asserts that the tumor varies in size, and that it causes less pain when large than when small. This is probably an erroneous observation. For ten days previous to her coming to my clinic no pain had existed. On examination I found an oval tumor with the long diameter corresponding with the axis of the finger, about the size of a large pea, located at the junction of the palmar and lateral surfaces of the finger, in the line of the digital artery of the ulnar surface. Pulsation synchronous with the ulnar artery was marked vertically and laterally, and ceased when the ulnar artery was compressed at the wrist. The artery was easily seen beating above the wrist, and evidently had an anomalous course over the deep fascia, instead of lying beneath it. It seemed to be nearer the long palmar tendon than usual. In the light of the previous case I advised excision, believing the growth to be either an arterial angioma or an aneurism of the digital artery; probably the latter. As the patient objected to such a procedure, I attempted to secure obliteration

by shutting off the blood supply. A pin was introduced through the tissues, close to the root of the finger, in such a way as to pass behind the artery going to the tumor. A tight ligature was then thrown around the ends of the pin. This greatly diminished the pulsation in the tumor, but gave much pain. The impossibility of avoiding compression of the corresponding digital nerve rendered me careful about making the ligature very tight or allowing it to remain when the patient was about to return to her home in the country. Pain became so severe that the pin was removed after the lapse of forty-five minutes. For five days subsequently I applied pressure to the ulnar artery, above the wrist joint, by means of a cork held in place with adhesive plaster. This was reinforced, during a considerable portion of the time, by digital pressure, exerted by the patient. It was thought that the tumor became softer and less pulsatile under this treatment. After some days it was discovered that pressure on the ulnar artery did not cause entire cessation of pulsatile movement, as it formerly had done; though this could be accomplished by moderate pressure on the radial in addition to the ulnar compression. I believed that increased radial anastomosis had been brought about by the continuous interference with the ulnar supply to the tumor, which I had effected by the pressure at the wrist. On the sixth day after applying pressure I and one of the pupil physicians dissected out the oval tumor, after having pushed aside the nerve which lay stretched over its surface. The wound was sutured, and afterwards healed slowly by second intention. The microscopic examination was made by Dr. Frederick P. Henry, and is given in his own words:—"The tumor is a simple angioma, containing, in portions, a large amount of young connective tissue. Where the connective tissue is more fibrillar in character the vascular walls are well defined, with concentrically arranged fibres; whereas in many portions they are mere spaces between the young fibres; and where these are cut transversely, the resemblance to sarcomatous tissue is very great. The entire absence of blood cells from the vascular spaces is explained by the fact that the Esmarch bandage was applied before the operation." A somewhat similar case is recorded by James Wardrop as having occurred in the practice of Mr. Lawrence. A pulsating tumor occupied the ring finger of the right hand, causing a general fullness of the first phalanx, though the chief swelling was on the palmar and ulnar aspects of the finger. The circumference of the digit was increased by about one-third. Pain was present. From the full description, it is evident that this was a more diffused angioma, or aneurism by anastomosis, than the pulsating tumor just described. Pressure on the main artery of the forearm was unavailing as a method of cure, and it, therefore, was followed

by ligation of both vessels by Mr. Hodgson. This also was unsuccessful in effecting a cure. Finally Mr. Lawrence made a circular incision around the growth, through all the soft parts except the blood supply, and thus caused atrophy of the pulsating and painful tumor. Numerous ligatures were required to arrest the bleeding from the wound.

The treatment of pulsating tumors of the hand is important, because of the disability and pain induced by the presence of the mass, and the possibility of sudden and dangerous hemorrhage. When there is pretty good evidence of the tumor being a true aneurism, and it is so situated as to make it probable that one of the palmar arches is the seat of dilation, ligation of the radial and ulnar arteries above the wrist is the proper treatment. I should try compression of these vessels first, but would soon abandon this method if no favorable result followed promptly, because prolonged pressure gives opportunity for the carpal or the median branch of the anterior interosseous to become enlarged, and, by the establishment of collateral circulation, to supply the tumor with blood. This would probably make the ligations at the wrist unsuccessful, and necessitate a second operation, such as excision of the sac, or ligation of the brachial artery. I have seen in the dissecting room an anomalous median artery about as large as the radial. This, however, is not a common anomaly; but if present in such a case of aneurism would render compression or ligation of the radial and ulnar arteries of little service. In all other cases of pulsating tumors, whether true aneurism of the smaller vessels, cirroid aneurism or pulsating angioma, it is better, as a rule, in my opinion, to excise them and ligate the bleeding points with catgut. The ease with which the dissection can be carried on with the aid of the elastic bandage makes the operation very satisfactory; and it is, of necessity, a radical method of cure. Lidell, indeed favors direct operative treatment in all palmar aneurisms. He advises to lay them open, turn out the clots, and tie the vessel at both ends. In cirroid arterial tumors in any position, Wyeth believes that no method of treatment is as safe and sure as direct local treatment, which may be by excision, subcutaneous ligation, galvano-puncture, and injection of perchloride of iron. In hard tumors of this kind, excision is probably the best. Spence reports a case of pulsatile tumor of the palm, injected with perchloride of iron, in which amputation was finally demanded. Keen records a similar instance, after the introduction of sub-sulphate of iron into the sac of a traumatic aneurism of the hand. Hence, I prefer excision, which is so free of liability to such a contingency. My rule, then, would be this: *In pulsating tumors of the hand and finger, excision is the preferable mode of treatment, unless the condition is a true aneurism of one of the palmar arches; then compression of the*

radial and ulnar arteries, at the wrist, and ligation of the same, may be attempted before resort to excision. I advocate, in aneurism of the arches, ligation of the arteries at the wrist, rather than excision of the tumor; because union by second intention will be the rule after the dissection of excision, whereas the clean cut incisions for ligation will probably heal primarily. Hence, as the probability of ligation curing aneurism of the arches is great, and the two incisions are more quickly repaired than the one in the palm, the method by ligature is to be preferred. In other pulsating tumors excision is better.—*Polyclinic.*

IRON DYED SURGICAL SILK.

BY H. PANCOAST A.M., M.D., PHILADELPHIA.

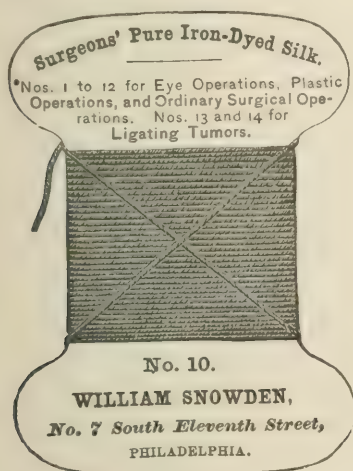
For several years past I have been in the habit of using black silk ligature, and for the past six years an iron dyed black silk. Its value I have demonstrated upon many occasions in my public clinics, and it has been reported upon in the medical journals, but I am earnestly requested to give a more detailed account of it. I was first led into its use by noticing in plastic surgery, and in operations upon the eyeball, that by employing the finest black silk from a lady's workbasket, the indications needed were best fulfilled. When flaps lie neatly and easily together, requiring simple, accurate juxtaposition, without any strain upon the suture, or where it was required to find the suture easily, a fine black silk ligature was strong enough for the purpose of support, and its color rendered it much more easily found, without the necessity of hunting beneath a scar or tearing flaps open. A pure black silk suture would cause very little irritation in its track, while a pure white silk of the same calibre would not only cause inflammation, but would become buried in the discharge and often hidden from view.

On enquiring among manufactures of silk, no pure white natural silk could be found. The natural hue varied from yellow to a dead white; the bright white color being produced by a lead dye. I believed that the lead was the cause of the irritation, and had some pure silk dyed with iron, which is fixed in the silk, and the silk finished with acetic acid. I also remembered that silk is an animal ligature, and that if properly prepared it might fulfil most of the animal ligature. With the assistance of Mr. Wm. Snowden, instrument maker, No. 7 South Eleventh street, various sizes of this iron dyed silk were made, as shown by the card, from No. 1, the most delicate, to No. 14 the strongest.

This pure iron dyed silk of these various sizes I have now been using with great satisfaction in clinical and private operations for the past six years.

The finest sizes are employed in plastic surgery and delicate operations, where great strength of the ligature is not needed; the medium sizes for ordinary operations, and the strongest when great strength is required. There is no stronger silk ligature than No. 14, and with it I have lifted heavy weights while testing its strength. Every surgeon appreciates the satisfaction of having a ligature upon the strength of which he can depend. The ligature silk is round, not plaited, strong, cheap, well finished, and durable.

In my operation for varicocele, which I have performed successfully at least three hundred times, I ligate the veins subcutaneously, tying the ligature No. 14 over a metal plate about the size of a silver dollar. I remove the plate as a rule in three days and withdraw the ligature. The shortness of time and success of the operation, I think, is greatly due to the strong ligature. I tie the veins as tightly as I can at the first operation, feeling confident that I may use all the force needed without fear of breaking the ligature. This first tie does the work. The



soft veins are thoroughly crushed against the metallic plate, and the consequent inflammation soon causes the effusion of the necessary plasma to block up the veins; the presence of this lump of plasma being an evidence of the cure by the destruction of the veins. The loop of silk which comes away is always very small, and contains only a small shred of cellular tissue. This subcutaneous ligature, with the strong ligature, is a certain cure, and my patients prefer it to the amputation of and shortening of the scrotum with the accompanying dangers of inflammation. The shortened scrotum after all must stretch and is only a support to the veins like a bandage, without curing the disease, the enlarged veins. This large, strong ligature is good for tying hæmorrhoids, if one prefers that form of operation. I use No. 14 for tying bleeding masses anywhere that I want strength. Some fifteen years ago I devised a bloodless way of dissecting out varicose

and other tumors. I pass large, strong steel pins of the size of those with which ladies fasten on their bonnets, six to ten inches long, through the base of the tumor, and then encircling the tumor beneath the pins, strangulate it with this strong ligature. I can then easily dissect out the tumor without being annoyed with bleeding. I have cured completely many fistulas with this No. 14 silk, passing it through the fistula and out at the anus, and then tying as firmly as I wish. I let the patient walk about attending to his affairs. As the ligature by its weight and pressure slowly cuts its way out, the fistula heals up behind it. I am particular to give it plenty of time. In operations for strangulated inguinal and femoral hernia I have been in the habit, after returning the healthy bowel, of sewing up the deep facial margins of the ring with medium strong black silk sufficiently to prevent a protusion of the bowel, and then bringing together the overlaying soft parts, skin, and superficial fascia, with other interrupted sutures. The deep sutures I leave without any concern. Sometimes they become enlarged and sometimes they are discharged in the pus, after having remained long enough to help to close up the depth of the wound. In inguinal hernia in the male, on drawing the margins of the external abdominal ring together, I am always careful to leave room enough for the spermatic cord. I once performed this operation on a baby boy about a week old, born with double strangulated inguinal hernia. One hernia I reduced after a hot bath, the other I operated upon and sewed up the wound as stated. The operation was a success, and the patient is now a strong young man.

As silk is an animal ligature it never disturbs me if it does not come away, whether in a deep wound or the ligation of an artery. If it becomes encysted it will give no trouble; if any irritation arises it will be discharged in the pus. The finest ligature Nos. 1 and 2, I have frequently left in the face for weeks; on one occasion for six weeks as an experiment. While the pure white silk sutures sloughed out or had to be removed, the fine black ones remained without exciting inflammation. Even after the wound had completely healed, the little black suture could be seen and turned around in its bed without producing irritation. The black silk is used by me freely in all scalp wounds where formerly I always employed silver. Silver or iron sutures I only use when there is weight or strain, as in big heavy or tense flaps, then I prefer strong wire to make a ring on the same principle as a ring in a pig or bullock's nose.

In the operation for hare-lip I depend upon the black silk, and very little on pins of any form. If I use pins I generally take them out on the second day, or cut the ligature from around them. I am careful to make the lip tie easily by loosening the cheek flaps freely from the bones of the face. In

making my incision through the edges of the gaping fissure of the hare-lip, I turn my knife delicately so as to make an apex of a small triangle on each side, and as I bring the knife down I save the flaps, made as Malgaigne suggested. The edges of the wound I then draw neatly together with the fine silk Nos. 2, 3, or 4, sewing together even the mucous membrane. In some cases this is all that is needed. In the severe forms of hare-lip, I strengthen the flaps with another stronger black suture outside of and to support the first, or use a toilet pin, or insect pin, wrapping Nos. 12, 12, or 14 around the pins ovaly, not in a figure-eight form. This last I cut away on the second day generally to examine the lip and prevent excoriation by the pressure of the ligature soaked in the discharges. If needed, I apply a ligature in the same way for another twenty-four hours. I think my success in this operation is greatly due to my being able to closely unite the edges of the incisions by this one and non-inflammatory silk.

PEPTONIZED MILK IN ACUTE DYSPEPSIA.*

The following article by John W. Brannan, M.D., of Colorado Springs, appeared in the *Boston Med. and Surg. Jour.* for July 18th, 1883. Physicians are often baffled and discouraged in attempting to treat a stomach so disordered as to be absolutely intolerant of all food. The various drugs known as digestives are tried in turn, and the most easily assimilable food is given. Milk in small quantities, either alone or with the addition of lime water, is often well borne, and in such cases a favorable result is merely a question of time. But in other cases the stomach, incapable of performing its functions, demands not simply *digestible* food, but food already *digested*.

Physiology has taught us the nature and workings of the digestive ferments of the body, and physiological chemistry has given us the active principles of those ferments. In selecting a food for artificial digestion we may reasonably choose that one which is most easy of natural digestion—that is, milk. The albumen of meat and eggs can be digested artificially by a solution of pepsine and hydrochloric acid, but the process is of five to eight hours' duration, and the resulting product is far from tempting to a fastidious stomach. Milk however, by the process I am about to describe, can be digested sufficiently in one hour or even less to be readily taken up by the absorbent vessels of the body. Its taste, when thus prepared, is not at all disagreeable. Moreover, milk contains all the proximate principles necessary to the

complete nutrition of the body. Of these principles the sugar, water and saline matters are already in a state fit for absorption. Milk sugar, though not absolutely identical with grape sugar, is closely allied to it, and, according to Pavy, behaves precisely like it in the alimentary canal. We have left then the casein and butter of milk, the former to be converted into albuminose or peptone, the latter to be emulsified. The pancreatic juice is the only ferment in the body which combines the properties of changing albuminoids into peptones, starch into sugar, and of emulsifying fats. The *Extractum Pancreatis* of FAIRCHILD BROTHERS & FOSTER, of New York, is the preparation I have employed in the following manner: Five grains of *Extractum Pancreatis* and twenty grains of bicarbonate of soda are dissolved in four ounces of tepid water. This is added to one pint of fresh milk, warmed to the temperature of the body, and the mixture is allowed to digest for about one hour at a temperature of 100° F. The milk, when ready, should have a slightly bitter taste, or rather after-taste. It is now raised to the boiling point, strained, and placed on ice, ready for use. In my experiments I found that the casein of the milk was not completely peptonized, nor the fat entirely emulsified, until the digestion had proceeded for two hours or more. But the milk becomes very bitter and disagreeable to the taste after such prolonged digestion, and in practice one hour's digestion seems to give the best results. As will be seen from the cases detailed below, this length of time suffices to render the milk easy of assimilation.

CASE I.—E. A., a child of nine years of age, is not yet very strong but has a fair digestion, as a rule, though with a tendency to constipation. In consequence of a succession of colds the child's strength became much reduced, and at the time of my first visit, subacute, passing into acute, dyspepsia had developed. The symptoms were nausea and vomiting, and epigastric pain on taking food. After trying a very simple diet and various digestives without good effect, peptonized milk was given as the sole food. All dyspeptic symptoms ceased at once, and after two days of this diet other articles of food were, one by one, permitted to be eaten, and were well borne. In five days from the beginning of the attack the child's digestion was apparently perfectly restored though she had not yet recovered her usual strength. There was marked constipation in this case, which was relieved by Seidlitz powders.

CASE II. is that of Miss B., a young woman of twenty-two, far advanced in consumption. Her digestion has always been rather weak. On the 10th of February, 1883, the patient complained of occasional nausea and vomiting, and also of a troublesome diarrhoea. The vomiting was checked for some time by milk and lime water, and the diarrhoea controlled by lead and opium. On Feb-

* Read before the El Paso County Medical Society, April 9, 1883.

ruary 23d the vomiting grew much worse, pepsine, lactopeptine, ingluvin, etc., were all tried, but to no purpose. At the same time the diarrhoea became almost uncontrollable, there being six or eight loose dejections daily. The stomach rejected all food, even of the simplest nature. Peptonized milk was now given, and was well borne by the stomach for two days, though the taste of the milk was disagreeable to the patient. There was no diarrhoea during these two days, although no astringent medicines were used. As the patient now began to have a strong repugnance to the peptonized milk it was discontinued, and a return to ordinary food was gradually made. During the month following her digestion remained very good, and but little medicine was required for the bowels. On the 21st of March there was again a little vomiting, accompanied with quite severe diarrhoea. Peptonized milk was at once ordered, but mutton and chicken broths were also allowed. The diarrhoea was checked with chalk and laudanum. Again the stomach responded to the milk treatment, though I had but little hope that it would. At the present time the patient's digestion remains fairly good, in spite of the steady advance of the disease in her lungs.

CASE III.—March 1, 1883, I was called to Mrs. C., a lady two months along in her second pregnancy. Her digestion had never been very strong. She was now suffering from almost constant nausea, which for a time was controlled by lactopeptine and ingluvin and a careful regulation of the diet. After a time these remedies failed of effect, and all kinds of food were vomited, though the patient maintained the recumbent position constantly. Previous to the advent of the nausea the patient had been taking six or seven glasses of ordinary milk daily, but now she could not bear even a very small quantity, having a great distaste to it. Peptonized milk was now given to the exclusion of all other forms of nourishment. The vomiting ceased almost immediately, and after a day or two there was no more nausea. Rest in bed was still maintained for three days; the patient was then able to get up and go about with no further dyspeptic symptoms. After five days of peptonized milk diet rare beefsteak was given once daily, and in a few days more the peptonized milk was given up entirely, the patient longing for plain milk and ordinary food. There has been no return of the dyspepsia, but the patient is, of course, very careful in her diet. She considers her digestion to be better now than it has been for years. In this case, as in the first, there was marked constipation. Pills of extract of nux vomica, hyoscyamus, and compound extract of colocynth were employed to combat it. As bearing upon the question of the rapidity of absorption of peptonized milk it may be well to note one incident in the history of this case. On the first day of the milk treatment the

patient had left her bed for some reason twenty minutes after taking a full glass of the prepared milk. The movement was followed by the vomiting of about a tablespoonful of greenish fluid. There was not a trace in it of the milk so recently swallowed. According to the physiologists two hours is the time taken by ordinary milk in digestion.

There are a few points to which I shall refer briefly in closing.

First.—It is essential that the physician in charge, or at least some one more intelligent than the ordinary servant, should superintend the first preparation of the milk. In the second case given above the milk was made too bitter on the first day, hence the patient took a distaste to it which she could not afterwards overcome. In the course of the hour taken by its digestion the temperature of the milk may be allowed to rise as high as 105° F. or fall as low as 98° F., but only for a few minutes at a time. It is best to keep it as near to 100° F. as possible.

Second.—In the process I have described, the pancreatic extract is not the only factor in transforming the casein into albuminose. According to the experiments of T. Schmidt a solution of bicarbonate of soda added to cow's milk diminishes the amount of casein and increases that of the hemi-albuminose. Again, the same observer proves that the process of boiling transforms a considerable amount of the casein into hemi-albuminose, and thus brings the composition of cow's milk nearer to that of woman's milk. We thus have three forces all tending to make the milk more assimilable for the stomach.

Third.—Though I have dwelt especially upon the utility of peptonized milk in acute dyspepsia, I am convinced that it would also be of service in many cases of chronic dyspepsia. The patient in Case III. had been a sufferer from greater or less dyspepsia for years. Less than one week of peptonized milk diet not only relieved all her acute symptoms, but also improved her digestion to such an extent that she can now eat and assimilate all kinds of food.

Fourth.—From its readiness of absorption peptonized milk ought to be well fitted for rectal injection. When used for this purpose its digestion might with advantage be carried much further than when prepared for the stomach.

Fifth.—The three cases I have reported are all in which I have had an opportunity to try peptonized milk as an easily assimilated food. Though few in number, the uniform success of the treatment has led me to publish them, with the hope that further trial by other observers may verify the results I obtained.

IN PHTHISIS AND BRONCHITIS, Renzi and Rimuno report good results from the inhalation by spray of iodoform dissolved in turpentine.

ACTIONS AND USES OF ATROPIA.

One of the physiological effects of atropia is diminution or arrest of various secretions. Thus dryness of the mucous membranes of the throat, mouth and nares has been noted after the ingestion of this drug. The secretory function of the skin is also suspended. Therapeutics has taken advantage of this moderating action on secretion. Thus, in the treatment of coryza, Dr. Gentilhomme, of Geneva, taking his departure from the fact that atropine diminishes the secretion, even causes dryness of the nasal mucous membrane, prescribes pills containing each one half milligramme of sulphate of atropine. At the onset of the coryza one pill is taken, and in an hour's time the sneezing will have ceased, the secretion will have disappeared, and the respiration become free. Sometimes a quarter of a milligramme ($\frac{1}{40}$ grain) is sufficient to produce this result. In chronic bronchitis the same favorable result has been obtained. In profuse salivation, from mercury, pregnancy (reflex salivation), etc., Gabler has derived benefit from atropine, in minute doses; he prescribes powders of atropine, containing each one-quarter of a milligram rubbed up with white sugar; one powder may be taken every four hours till the physiological effects of the drug are experienced.

This same authority has prescribed atropine with success in cattarrhal diarrhœa, giving from one-fourth to one-half a milligram every five hours till toxic manifestations appeared. There is, perhaps, no better remedy with which to combat the profuse night-sweats of phthisis. As an anhydrotic it has a high place in the practice of physicians all over the world. Dr. J. Milner Fothergill recommends doses varying from the seventy-fifth to the fiftieth of a grain. Vulpain ("*Clinique Méd*" p. 338) advises pills of sulphate of atropine, each containing one-half milligramme. Of these, two pills, one hour apart, in the evening. If this is not sufficient, give another about the middle of the afternoon. It is rare, he says, that more than three pills a day are necessary.

Bartholow, who prefers atropine to any other remedy for night-sweats, is much in the habit of prescribing a pill of $\frac{1}{80}$ of a grain three times a day; besides acting as an anhydrotic it facilitates respiration.

That well-known sedative action which atropine exercises on the peripheral terminations of nerves, and on the elements of the nerve-centres, may, irrespective of any supposed constrictive effect on the vaso-motors—which is an effect by no means constant—explain the use of this medicament in affections of the cerebro-spinal nervous system characterized by phenomena of excitation, such as pain, spasm, convulsions, epilepsy. By this sedative action Gabler (also Trousseau and Pidoux) account for the remedial efficacy (so often noted) of bella-

donna and its alkaloid in rheumatismal and other inflammations of the spinal cord and its membranes. Under the influence of this drug, the pain and numbness and contracture of the extremities often give way rapidly.

In nocturnal incontinence of urine, atropine, by allaying irritability of the muscular fibre of the bladder, or producing stupefaction of the mucous membrane of that viscus (eminent authorities, as Gabler, believe that both effects are brought about as the result of the physiological action of the drug) proves an invaluable remedy. One grain of sulphate of atropine may be rubbed up with one hundred grains of white sugar and divided into a hundred powders. Of these, one may be taken at bedtime by a child twelve years old. Or one drop may be given at bedtime of the solution of sulphate of atropia of the British Ph., which consists of two grains sulphate of atropine to half a fluid ounce of distilled water. If this should be inefficacious, the second night two drops of the solution may be administered, which will, without doubt, give the physiological effect of the medicament. The dose must gradually be increased according to the necessity of the case.

In pertussis, one of the best remedies is sulphate of atropia, and, given according to Bartholow's formula, it is sure to give relief in the spasmodic stage where there is profuse bronchial secretion. One grain of sulphate of atropine is dissolved in an ounce of cherry-laurel water; of this two drops may be given three or four times a day. We have used this remedy with advantage in whooping-cough in the form of spray; the liquid in the atomizing cap of a spray-producer or steam atomizer being charged with five drops of Bartholow's solution. Atropia has a remarkable sedative or stupefying effect in irritable nerve-terminations when applied locally, and the quantities of the medicament that may be used with benefit are really infinitesimal. The above solution makes a good liniment in painful neuralgias, but must not be rubbed above the orbit for obvious reasons.—*N. Y. Med. Rec.*

HYDROBROMIC ACID AS A SUBSTITUTE FOR THE BROMIDES.—Dr. Dana stated at the annual meeting of the American Neurological Association, that this acid had been used by the profession chiefly with quinine, under the belief that it prevents or lessens cinchonism. The only extended record of clinical observations regarding this acid that he had been able to find was one by Massini, published two years ago, who used it in thirty-one cases of various kinds without special benefit. Dr. Dana was led to experiment with the drug, with the hope that it would produce the beneficial effects of the alkaline bromides in epilepsy without causing depression and scurvy. He had now used hydrobromic acid in the treatment of various nervous

affections for nearly two years at the Northeastern Dispensary, and he had the clinical notes of over fifty cases of various kinds. The officinal dilute acid is a ten per cent. solution, of which the dose would be from one drachm to two drachms and a half, well diluted. In *epilepsy* some patients received marked benefit from the use of the acid in doses of four to five drachms a day. Dr. Dana believed, however, that in *epilepsy* hydrobromic acid could not be used as a substitute for the bromides, except in the non-controllable cases, and yet it undoubtedly has a controlling influence over the disease. In *chorea* he thought the acid could be used advantageously as a medium for arsenic or strychnine when it is desired to give a sedative. In *alcoholism* it failed in two cases, the patients being on the verge of delirium, and the bromides with chloral were subsequently given with relief. Hydrobromic acid is a good solvent of quinine, but it *does not prevent cinchonism*, as has been asserted, certainly not in the small doses usually prescribed. In most cases of *insomnia* it also acts well. He could say positively that he could give the acid with just as much confidence that it would produce nervous sedation as when the alkaline bromides are prescribed. He had never seen any sign of bromism or any disagreeable constitutional effect other than some drowsiness. He believed that the ordinary custom of prescribing from twenty minims to one drachm of the three per cent. solution, the strength ordinarily employed, or of a ten per cent. solution, was generally much too small a quantity. Theoretically, in order to get the sedative action, from a drachm and a half to two drachms and a half of the ten per cent. solution must be prescribed. Practically he had found that very satisfactory sedative effects could be produced with drachm doses of the officinal dilute solution. In conclusion, the acid could be substituted for the bromides in all the milder affections for which the latter are used. It had appeared to him to be especially efficient in producing vascular and nervous sedation in the post- and prehemiplegic conditions. Unless given in very large doses, it takes several days to get its best sedative effects. Dr. W. A. Hammond stated that he used hydrobromic acid for seven or eight years, and then abandoned it because he did not see that it did any good. He had found, however, that it does prevent the unpleasant effects of sulphate of quinine; but in this respect it is not so efficacious as a corresponding dose of the alkaline bromides. Dr. Hammond's experience concerning the power of this acid to prevent cinchonism was corroborated by Dr. Eskridge, of Philadelphia, who also spoke of the good effects of the drug in typhoid fever.

MORBID CHANGES OF THE THROAT, LARYNX, AND AIR-PASSAGES IN SOME ACUTE INFECTIOUS DISEASES.—Dr. E. Löri, of Buda-Pesth, gives the

following as some of the changes which may be observed. In measles, twelve to thirty-six hours before the appearance of the skin rash, there is a diffuse or macular hyperæmia of the mucous membrane of the throat, larynx, air-passages, diffuse usually in the mouth, macular on the tonsils and back of the throat. Within twelve hours from the appearance of this hyperæmia there occur small papules, first on the palato-glossal folds. About the time that the skin eruption appears there is profuse catarrh of the pharynx, larynx, and trachea, with rapid shedding of the epithelium, and frequent formation of superficial erosions. In the trachea the swelling around these latter may give rise to stenosis. According to the writer, the appearance of such ulcers in the larynx augurs the occurrence of tuberculosis. In scarlatina, the throat is affected twelve to thirty-six hours before the outbreak of the eruption. The writer states that there is often a sudden disappearance of the affection of the mouth and pharynx coincident with the eruption on the skin coming out. Frequently the eruption in the mouth closely resembles that found with measles. In rubeola there is also hyperæmia, diffuse or spotted, of the larynx and trachea. In smallpox the mouth is affected at the same time as the skin. The pustules are small and imperfectly filled, dry up in two or three days, and in six days are only represented by red spots. Bleeding from them is very common. The writer recommends the use of ice poultices round the neck, ice internally, and such astringents as tannin applied after puncture of the pustules. In chickenpox there occurs either diffuse hyperæmia of the mucous membrane, or a few scattered pustules. In typhus and typhoid, acute catarrh of the pharynx, larynx, and trachea is of frequent occurrence, and often proceeds in the larynx to the formation of ulcers, which have little tendency to heal, and occasionally, about the sixth or eighth week of the disease, cause perichondritis. For this latter condition, "when diagnosed with certainty," the writer recommends tracheotomy as early as possible. In whooping-cough there is usually some catarrh of larynx and trachea, and bleeding from the mucous membrane is frequent. The appearance, during the course of whooping-cough, of ulcers in the larynx, the writer regards as very suspicious of the onset of phthisis.—*Edinburgh Med. Journal.*

ACTION OF DRUGS ON SECRETION OF MILK.—

We are already acquainted with the fact that a certain number of medicines when ingested by the ordinary channel were, in part, eliminated by the secretion of milk, but we do not possess precise information concerning the influence of the medications on the quantity and quality of the secretion. Observations recently made by M. Strumpf on the milk of goats as well as on the secretion in the human female during lactation have in a measure

supplied this want. Iodide of potassium was found to lead to a marked fall in the quantity of the fluid secreted, the proportion of proteid and saccharine principles were increased, whilst the proportion of fat was diminished. The quantity of iodide secreted was very small, so that the notion that iodide of potassium can be administered to children by way of their nurse is not sustained. Alcohol increased the richness of milk in fats, whilst the proportion of albuminoids and carbohydrates was not modified. Unaltered alcohol was not detected in the milk. Neither alcohol, morphia, nor the preparations of lead had any influence on the quantity of the secretion. Salicylic acid seemed to excite secretion a little; pilocarpine exercised no effect in this direction. The richness of the milk in sugar was increased by salicylic acid, which passes out of the milk secretion in greater quantities in the human female than in the herbivora. Traces of lead were also recognisable in the milk of those subjects who were ingesting the preparations of lead.—*Lancet*.

A METHOD OF RENDERING THE SKIN INSENSIBLE IN OPERATIONS.—The *Medical Press* gives the following, reported at the Académie des Sciences:—A lady, aged sixty years, had a scirrhus tumor in the right breast of eight years' standing. The general health was bad, bronchial and cardiac troubles were manifest, and the kidneys were not in a satisfactory condition. The operation was urgent. Chloroform having been considered dangerous, M. Guérin applied around the tumor a circular layer of Vienna paste, limited by a double band of diachylon. At the end of twenty minutes the caustic was removed, leaving in its trace a black ribbon-like line. The knife was then applied, and the tumor removed without the patient feeling the slightest pain, and who did not seem to be aware of the operation. The results were all that could be desired.

CURIOUS EFFECT OF A CATHARTIC PILL.—Professor, bowing courteously (to patient just arrived from the Old Country, and to whom he had ordered a c. c. pill the night before): "What sort of a passage did you have, madam?" "Beautiful, doctor; passed two schooners and a sloop."

THE Dayton, O., Board of Health discharged the Health Officer and appointed a vigorous Democrat in his place. The Dayton *Journal* adds that "it was the deliberate opinion of the Board that the sanitary condition of their party demanded a Democratic doctor."

SOMETHING WORTH HAVING.— "Dermatologists are well aware that soaps made from rancid fats or by careless methods act as irritants to the skin, and both set up and maintain diseased con-

ditions of its surface. A pure soap, carefully made from vegetable oils, is something worth knowing and having. We can speak from personal experience that Packer's Tar Soap meets these requirements. It is exceedingly smooth and agreeable to the skin, and as it is combined with pine tar and glycerine, it is valuable as a remedy in skin diseases, as well as pleasant for toilet purposes. We commend it, without hesitation, as the most satisfactory soap, in both these respects, that we have ever used."—*Medical and Surgical Reporter, Phila.*

TREATMENT OF ECZEMA OF THE GENITALIA, PRURITUS AND LEUCORRHOEA.—In cases of eczema, in which glyceroles and unguents have failed, the following formula has been successful:

R—Chlorate of potassium 30 grains.
Wine of opium 50 grains.
Pure water 1 quart.

Applied to the parts by linen compresses covered with oiled silk. If there is much inflammation, precede this with warm hip baths and cataplasms sprinkled with powdered carbonate of lime. In obstinate pruritus, associated with leucorrhœa, a tablespoonful of a mixture of equal parts of tincture of iodine and iodide of potassium, in a quart of warm tar water (tar water holding the iodine in solution) used daily, night and morning, removes the pruritus and ameliorates the leucorrhœa. In fetid leucorrhœa two or three tablespoonfuls (in a quart of warm water, morning and evening, as an injection) of the following formula will be found useful:

R—Chlorate of potassium 13 grams.
Wine of opium 10 grams.
Tar water 300 grams.

Or,

R—White vinegar (or wine) . . 300 grams.
Tinct. eucalyptus 45 grams.
Acid, salicylic 1 gram.
Salicylate of soda 20 grams.

One to five teaspoonfuls in a quart of warm water as an injection two or three times a day.—*Obstetric Gazette*.

THE TREATMENT OF POST-PARTUM HÆMORRHAGE.—This note of Dr. Barnes's (*Lancet*, Jan. 27, 1883) was suggested by a recent article by Mr. Coates on "Two Cases of intra-venous Injections of Fluids for Severe Hæmorrhage," in which it was shown that injections of simple water had no bad effect upon the blood globules. He approves of this method of treatment, but thinks that saline injections are better. It is especially necessary to have a good canula. As might be expected, he has something to say in regard to the use of iron solutions for the arrest of post-partum hæmorrhage. The principle which he insists upon is that, when the diastaltic function of the heart is suspended,

"persistence in remedies which act through that function is useless, and may be injurious;" hence a local styptic action is desirable, and it is obtained from solutions of iron. He believes in strong persulphate, one to eight being the strength which he prefers. His concluding words are very valuable: "The first thing to do is to take care that the uterus is free from blood or clots. To insure this, a stream of hot water should be first sent through. This is a last appeal to the diastaltic force. If it check the hæmorrhage, the iron will not be used. But often it will fail; then the iron comes to the rescue as the last resource. About eight ounces should be injected slowly and gently. I have well weighed the advantages of swabbing, and prefer the method by injecting. With those who see no danger in hæmorrhage, or who argue that it can always be checked by 'ordinary means,' it is useless to reason. Nor can the dictum that the remedy is worse than the disease command respect. Hæmorrhage kills if not checked. It has often killed when the 'ordinary means' have failed."

CASCARA AS A LAXATIVE.—Dr. Carter of Liverpool, in an article on new therapeutic agents, writes to the following effect concerning cascara (*Rhamnus purshiana*): The fluid extract prepared from the bark of this shrub, or small tree, is an excellent remedy in chronic constipation. I have used it now for two years, and have no doubt of its value. The fluid extract is reddish brown in color, and extremely bitter. A very good method of prescribing it is in a mixture, with twice its quantity of glycerine, or one of the flavored syrups. Of this a fluidrachm should be given three times a day, and the dose be diminished as soon as its aperient action is developed. It is what may be termed a tonic aperient, and seems to produce an effect somewhat like that caused by belladonna and nux vomica united with an ordinary aperient. It evacuates the whole canal. The motion is not watery, but usually semi-solid, truly feculent in character, and voided without difficulty, and so far from causing subsequent constipation, the bowels will often act regularly after its use has been entirely discontinued. I have used it so extensively, and the testimony to its value is so unmistakeable, that it would be difficult to select particular cases to prove this.—*Medical Record*.

NEW TEST FOR ALBUMEN IN URINE.—Arthur R. Haslam writes to the *Chemical News* as follows: While recently engaged in some experiments, I had occasion to add a solution of chloride of iron to a diluted solution of albumen into which, some time previously, a small quantity of chloride of sodium had been thrown. The result was the formation of a dense opaque white precipitate. This precipitate, when well washed and dried, still contained iron, from which circumstance I should

suppose it to be a compound of albumen and iron. I have experimented on this reaction as a test for albumen, especially for that form which it assumes in urine, and it appears certain in its results, and has some advantages in its favor over the old nitric acid test, being much more delicate. After a series of experiments, I have adopted the following method of using the test: A portion of the urine supposed to contain albumen is poured into a test-tube, and a few drops of a solution of chloride of sodium added and well mixed; then a solution of chloride of iron is carefully poured down the tube, forming a layer. If the appearance of a whitish cone be noticed, albumen is present. If phosphates are present in the urine, care must be taken to add (before using the test) sufficient acetic acid to make the urine acid.

NOTE ON DISINFECTANTS.—In the *British Medical Journal* Dr. W. E. Buck writes: Most practitioners must have often realized the inefficiency of disinfectants in allaying the fœtor of cancerous ulcers, an annoyance which sometimes troubles patients even more than the pain, or the thought of death. I have used the whole round of disinfectants for cancerous ulcers, but all have failed in allaying the fœtor and keeping the ulcer clean. The disinfectants tried were carbolic acid, sanitas, terebene, resorcin, creasote, boroglyceride, chloride of zinc, charcoal, etc. After failure with these, I tried a saturated solution of hyposulphite of sodium added to an equal quantity of water, and found it exceedingly efficacious. The ulcerating surface was well syringed and washed with the solution, and was then covered with rags steeped in it. The granulations were kept clean, and the fœtor was well kept under. Most disinfectants seem to lose their virtue after a few days application, but I have used this one for months in the same patient with continuous good effects. It is cleanly, has no smell, does not stain, and is very cheap.

TREATMENT OF PUERPERAL CONVULSIONS BY HOT BATHS.—In a paper by Dr. Carl Breus, in the *Archiv für Gynækologie*, is given an account of eleven cases of puerperal convulsions treated by diaphoresis produced by means of hot baths. Other means, as the inhalation of chloroform, and the administration of chloral hydrate, were also employed. The convulsions set in at different periods during labour, and in the course of the first day after delivery. In four cases they came on at the beginning of labour, in two after the first stage had lasted some time, in one during the second stage, and in four a few hours after delivery. One only of the eleven cases died. There was present in all the cases albuminuria, together with more or less œdema. The baths were employed after the convulsions set in, during and after labour. A case is also mentioned in which forty-five hot

baths were given during pregnancy. The author believes that the immediate danger of life in these cases is due to the diseased state of the blood—hydræmia—shown by the albumen and anasarca; and that the rational treatment of this condition consists in the production of a rapid change in the blood-state. This he believes is brought about by profuse sweating, which, he states, diminishes the quantity of albumen in the urine, and the œdema. The hot baths have occasioned no bad symptom in the author's practice; they have not brought on premature labour when used during pregnancy, nor have they occasioned hæmorrhage when employed soon after labour.—*Lancet*.

DIPHTHERIA AND CROUP.—Dr. R. Wood, in *Midland Medical Miscellany*, translates the following from *Centrallblatt für Med. Wissenschaften*, March 24th: "Dr. Kenock draws a strongly marked distinction between Diphtheria and Croup. He says (a) In diphtheria there is very little fever, whilst in croup the fever runs high. (b) In diphtheria both sides of the throat and posterior wall of the pharynx are affected, and even the uvula becomes covered with membranes sometimes; whilst in croup only one side is affected at first, and the uvula is comparatively free. (c) In diphtheria the mucous membrane of the nose seldom escapes, whilst in croup it always does.

ECZEMA.—Dr. Simon, in *Birmingham Medical Journal*, thus sums up a paper on Eczema:

1. Catarrh of the skin.
2. Its local manifestation may be Erythema, Papule, Pustule, or a Vesicle.
3. It may commence acutely and tend to spontaneous recovery, or to chronicity.
4. In chronic, not only are vesicles formed, but exudation takes place into true skin.
5. Such exudation must be removed, which must be by absorption of the medicine by the blood vessels.
6. Hard water must be always avoided.
7. Lotions do good, ointments do harm.
8. Air should be excluded.
9. Water should be used but little.
10. Crusts must be removed.

NASAL CATARRH.—Cubeb is the remedy most relied on in the Throat room, for constitutional impression in the ordinary form of the complaint. Fifteen or more drops of the oleo resin, on sugar, after meals; or a few grains of the recently prepared powder, with two or three grains of salicylate of cinchonidia, in pill or capsule, are the forms in which it is usually prescribed. Cleanliness, by douche or spray, is essential in giving the parts a chance to get well, which they often will do by cleanliness alone, without any topical medication.—*Polyclinic*.

LACTOPEPTINE in Gastric Disorders of Children.—By Aubrey Husband, M.B., F.R.C.S., Medical officer to Royal Dispensary, Edinburgh. "Of all the disorders to which young children are liable, those affecting the digestive organs are at once the most common and the most fatal. It has been calculated, from the Registrar-General's report, that one-quarter of the deaths among children under five years is due to diseases of the digestive organs, and this fatality is considerably greater under one year. Passing from these general considerations I would specialize one or two diseases which, from their constant recurrence, cannot fail to attract attention, and in which I was enabled to watch the effect of Lactopeptine.

"The cases are those of rickets, and of so-called atrophy with dyspepsia and diarrhœa. The following cases are of this type.

"1. C. D., æt. 3. The little patient had all the symptoms of rickets. She had a heavy, stupid look, the chest much contracted laterally, and the bones of both legs and arms much affected. She was ordered 5 grs. lactopeptine after each meal, and under this treatment the child gradually, and then rapidly, improved.

"2. M. W., æt. 2. This child was found suffering with symptoms of gastric derangement, colic, vomiting, and loss of flesh. As the diet had always consisted of anything that could be obtained, from dried cod and cheese, and as there was no chance of providing more suitable food for the child, it was hoped that by the aid of lactopeptine the diet might be made more digestible and nourishing. Accordingly 5 grs. lactopeptine was given daily after food, and the result was more favorable than was expected—the little patient after a short period becoming quite well.

"3. J. M., æt. 7½ years, was evidently of strumous habit, losing flesh rapidly, felt pain after taking meals. He could not take cod-liver oil. There were no chest symptoms. He was ordered 5 grs. lactopeptine three times daily, which was continued for a month, when he was able to take the oil and speedily recovered.

"The above cases serve to demonstrate the value of lactopeptine in the treatment of gastric disorders of young children. In two cases of children of a mother in the last stages of phthisis, the lives of the babes were saved by its use."—*The Medical Press and Circular, Lond.*

IODIA.—Dr. Carl Seiler, late Director of the Microscopical and Biological Section of the Academy of Natural Sciences of Phila.—Lecturer on Diseases of the Throat, University of Pennsylvania, Philadelphia, Pa., says: "I have used the preparation called Iodia, as manufactured by Battle & Co., of St. Louis, both internally and locally by means of a spray in cases of throat affections, and found it admirably suited to certain cases."

THE CANADA LANCET.

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CHOLERA INFANTUM.

The king of terrors has but few allies more powerful than cholera infantum. In all quarters of the globe it counts its innocent victims by thousands. It has cast its dark shadow on most households, and notwithstanding the boasted advance of medical science, it is the terror of the fond mother and the dread of the family physician. It is not on account of anything new or important we have to say that we take up this subject, but because it is proper that a disease so wide-spread and fatal should receive at least a passing notice at the season of its greatest prevalence.

Dentition and heat, especially the latter, being the leading factors in the production of cholera infantum, medicinal agents proper are comparatively powerless. No medicine can stop the teething process, nor moderate the heat of summer. We may lull to sleep dental irritation, and we may reduce the bodily heat, but we never can wholly remove the causes. Both the prevalence and fatality of this disease vary greatly from season to season. Dry, and long-continued hot weather is most favorable to its development. This summer being moist and cool, the disease should not prevail to the same extent as in ordinary seasons. Should it do so in any particular locality, it must be owing to bad sanitary conditions. If medical science were a failure in all other respects, one great and grand thing it has done, it has taught man how, in a large measure to protect himself against the ravages of disease. If medicine furnishes no cer-

tain cure, it is a satisfaction to know that the disease may be in a large measure prevented. Due regard to diet, clothing, cleanliness and purity of air is a pretty effective safeguard. Over-feeding should be avoided, even in the case of infants at the breast. Nurses should regulate their own diet so as to avoid all articles of food known to have a disturbing tendency on digestion. During the heated term children fed on cow's milk should have their allowance mixed with barley-water, oatmeal-water, or a small quantity of lime-water. The reprehensible practice of giving infants "a little of whatever is going," cannot be too strongly condemned, at any time, but more especially during the hot weather. Next in importance to dieting is pure air. If, in addition to the depressing influence of heat, the child is made to breathe the atmosphere of a close room, occupied, perhaps, by one or more other persons, cholera is almost inevitable. A free interchange of air has a wonderful power in preventing diseases in general, but diseases of the digestive organs in particular. As another means of prevention, the child should be allowed to drink a moderate amount of cold water. Even infants of a few weeks old are greatly refreshed and benefited on a hot day by a little cold water. Bathing is another hygienic measure of great value, and should never be overlooked in health or disease.

It is much more difficult to be dogmatic in the matter of treatment. This naturally resolves itself into two parts, the hygienic and medicinal, the former being by far the most important. Much of what has been said in reference to prevention is applicable to treatment. The patient should be at once placed under sanitary conditions as favorable as possible. If the case is at all severe at the outset all food had better be withheld for a time, even breast-milk. It is not digested, and only increases irritation. The child craves for cold water, but experience teaches us that gastric and intestinal irritation of whatever kind, is not relieved, but rather increased, by draughts of cold water. But when the temperature is high, and thirst great, a teaspoonful of iced water repeated at short intervals will at least prove grateful. In this disease the drain on the circulating fluids is great. To compensate for this, it is necessary to give a good deal of liquid in some form. Sometimes the disease is ushered in with such suddenness and se-

verity as to cause death in a few hours. In such cases the vomiting and purging are excessive, the skin is cold and the distress is extreme. When death does not soon take place, reaction sets in, and instead of coldness there will be heat of body. These different conditions, of course, require different management. In the former we must endeavor to supply heat, by the hot bath, persistent friction, mustard sinapisms, tincture of capsicum rubbed along the spine and on the extremities, and warm drinks, with stimulants. These measures must not be carried to excess, and must be discontinued as soon as reaction is observable. It however, more frequently happens that the onset is more gradual. Instead of diminished, there is increased temperature calling for measures directly the opposite.

The judicious management of the child's food and drink is, without doubt, by far the most important part of the treatment. Medicine can do no good as long as materials are poured into the stomach which it is unable to appropriate. It is worse than useless to allow an infant to nurse simply that it may vomit immediately after. It surely cannot be right to administer milk or other food which we know will be rejected. The child, so far from being benefited, is made worse, and the symptoms which we are endeavouring to relieve are aggravated ten-fold. No food at all is to be preferred by far, to food which is taken only to be rejected by an exhausted stomach. Great irritability of the stomach may be regarded as proof positive of its inability to digest milk. In such cases we must rely mainly, for a time at least, on barley-water, which has been made somewhat as follows : To a pint of cold water add one or two teaspoonfuls (according to the age of the child) of barley which has been freshly ground or broken up in a coffee mill, or in some other way ; let this be boiled down to one-half and strained while hot. This, like all else, should be given warm—simply warm. Salt should always be added. After the stomach has become more quiescent, and it is thought some degree of digestion can be performed, milk in varying proportions may be cautiously added to the barley-water, or milk and lime-water may be given. Barley-water and lime-water have the quality of preventing the solid curding of the milk, which usually takes place in these cases. We can also recommend with confidence the following : Beat

up the white of two eggs in a goblet ; fill the goblet two-thirds full of cold water and beat again. A few grains of sugar may be added, a little salt, together with a little orange or peppermint water to flavor. This may be given frequently in tablespoonful doses, throughout all stages of the disease. It is nutritious and palatable, and often retained when all else is rejected. It is very important to impress upon nurses that under no consideration are large draughts of any kind admissible, not even breast milk, when that is allowed. Small quantities frequently repeated is the true method of feeding in all severe cases.

The strictly medicinal part of the treatment has been considerably narrowed down of late years. Every practitioner of experience has been disappointed and humiliated by the inefficiency of his drugs. Astringents are constantly prescribed, but every one knows that they exercise no influence for good in the more severe cases. Pepsin, malt-pepsin, lactopeptine and bismuth constitute the main remedies of the hour, and there can be no reasonable doubt of their value. Other remedies are added according to the fancy of the prescriber or as the symptoms seem to indicate. For nervous excitement and great restlessness, nothing is equal to chloral hydrate, given in one or two grain doses, according to age, and repeated as often as necessary. Given in this way, no evil will ensue. Children are very tolerant of this drug. In some quarters it is much vaunted as a remedy in Asiatic cholera. We can testify to its beneficial effects in some cases of cholera infantum.

BRITISH MEDICAL ASSOCIATION.

The fifty-first annual meeting of the British Medical Association was held in Liverpool, July 31st and three following days, under the presidency of Dr. Waters, and was a largely attended and most successful meeting. The subject of the president's address was the "Present condition and future prospects of the profession." Last year the Association celebrated its jubilee, and much retrospective oratory was indulged in ; this year it seemed fitting to consider the present condition and future outlook of the profession, and this subject was handled with much ability by the learned gentleman. He alluded to the endeavor now being made to render our knowledge more defi-

nite and exact by the introduction of instruments of precision, as, the stethoscope, the thermometer, microscope, sphygmograph, and laryngoscope, and dwelt especially on the use of the stethoscope, thermometer, laryngoscope, and sphygmograph. He next referred to the improvements in therapeutics, ever bearing in mind that medicine must be judged by the therapeutic results which it achieves. In illustrating this point he alluded to the practice of tapping the chest in pleuritic effusion, the treatment of continued fevers, etc., but while we look with satisfaction upon our successes, we must deplore our imperfect knowledge of both the pathology and therapeutics of some diseases, as diabetes, rheumatism, etc. He alluded hopefully to the present and prospective labors of the "Collective Investigation Committee" of the Association as capable of accomplishing most valuable work in this direction. One line of enquiry he trusted would receive special attention at their hands, viz., the points of difference between functional disturbance and the early symptoms of organic affections, for, said he, "how difficult it is sometimes to say, when some slight symptom presents itself and when no objective signs of organic disease can be discovered, whether that symptom indicates incipient structural change or mere functional derangement." He then referred to the all-absorbing question of the dependence of certain diseases on micro-organisms, and classed these as the most striking discoveries of the present day, and fraught with bearings of a practical kind in the prevention and treatment of disease, in which he alluded especially to the *Bacillus tuberculosis*. He next referred to the introduction of substances by the chemist of the highest value to the physician in the treatment of disease, such as the bromine compounds, chloral, croton-chloral, pepsine, and the various forms of pancreatine, salts of salicylic acid, etc. In conclusion he ventured to think that amongst the many changes which revolving years would bring, and the higher status as a science which medicine would attain, and the higher estimation in which the profession would be held, there would come a fuller recognition of the claims of its members to some of the higher honors of the State; and perhaps the president of that occasion, or some who may listen to his words, may belong to that upper branch of our Legislature to which hitherto no practitioner of our art has reached.

The address on surgery was delivered by Reginald Harrison, F.R.C.S., who took for his subject "Some recent advances in the surgery of the urinary organs." He referred to such subjects as nephrectomy, Bigelow's method of lithotrity, cystotomy in vesical troubles, urethrotomy, etc. The address which is of a practical and interesting nature, was well received and his views in the main concurred in.

Dr. Creighton delivered the address on pathology, taking for his subject the "Autonomous life of the specific infections." In the course of his remarks he said that the central principle in the doctrine of disease is that diseased states are but modifications of healthy conditions, deviations from the physiological standard. Thus, he says, even in so formidable a malady as diabetes, we are still within sight of the line of health; there may be a physiological glycosuria, and that fact, says Dr. Bence Jones, proves that the disease is only a little way distant from health. There is no definite limit, where health ends and disease begins. In dealing with the subject of his address proper, he dwelt at length upon the autonomous life of cancer, bovine tubercle, and smallpox, the last of which he claimed possessed it in a high degree, inasmuch as it has preserved its unity and individuality in all races of men, in all ages, and all parts of the world. He next referred to the exogenous infections, as cholera, yellow fever, etc., and alluded to their capability of subsistence for long periods outside of the human body, but which require certain conditions to render them potent. The arguments in favor of his theory, though far from convincing, were fairly well sustained.

The Sections were largely attended, except those on Physiology and Pathology, in which the attendance was less numerous than it should have been. The entertainments were of the most hospitable and brilliant character. A soiree was given by the president and local committee, a reception by the mayor, and excursions were made to various points of interest in the vicinity, the affair being brought to a close by a grand banquet on the 3rd of August. Dr. Cuming, of Belfast, was elected president, and Belfast selected as the next place of meeting.

Dr. John Marshall has been elected President of the Royal College of Surgeons, England.

THE CHOLERA.

At a meeting convened by the National Health Society of London in reference to the probable outbreak of cholera, Dr. Ernest Hart, editor of the *Brit. Med. Journal*, made some very excellent and appropriate remarks. He was introduced to the meeting by Sir Richard Fayrer who presided. In introducing the lecturer he said it was an undoubted fact that cholera was prevailing in the Delta of the Nile and it therefore behoved the English people to be prepared for a possible extension of the disease to this country.

Dr. Ernest Hart said that materials for such a lecture abounded in every direction. With an increased knowledge of the laws of disease, we had been enabled to make each successive epidemic less severe. Cholera first invaded Europe after the introduction of steamboats, and in 1831-2 there was a very-widespread epidemic which reached this country. In India our experience of it dated from 1808. The epidemic of 1831-2 first appeared in Russia, and despite quarantines and cordons, it gradually assailed every country in Europe. In 1848 there was a second great epidemic, and for the first time we rationally investigated—according to modern methods of investigation—the nature and causation of cholera. We then saw the clear connection between cholera and unhealthy conditions of life. It raged in different parts in proportion to the impurity of the water supply. The connection of water supply with cholera, Dr. Hart dealt with at considerable length. Pure water, he said, was a condition of primary importance in the prevention of an epidemic, and we had a right to expect thoroughly pure water from the monopolist companies. It was an anomaly that there were no penalties which could be enforced for the distribution of impure water. Others were not allowed to disseminate unhealthy things. A very small pollution of a vast body of water was capable of conveying to the whole of that body qualities which would produce an epidemic of cholera. To prevent the spread of the disease neither quarantines nor cordons were to be relied upon. Both had been proved by the experience of the whole of Europe in its calmer moments, and by the unanimous expressions of opinion of our Indian officers, to be cruel, selfish, morally wicked, and medically use-

less. Quarantine was an ancient and barbarous expedient which had been condemned by every authority which had examined into it. Common sense and cleanliness, were two far better things to fight cholera with than quarantines and cordons. At the Vienna Conference quarantine had been pronounced to be "impracticable and useless;" while a system of medical inspection was recommended to be adopted. Still more useless than quarantine was a system of cordons. There were four great things to be looked to—the air, the water, the soil, and personal precautions. As regarded infected air, it was known that cholera spread in precisely the same way as typhoid and enteric fever and diphtheria. Care must be taken after the ordinary means of ventilation, that houses were perfectly and properly drained, and that no sewer-gas could enter. Cholera was not a mysterious disease, passing from hand to hand, from individual to individual, and from distance to distance, by any unexplained means. English and European experience went to show that if pure air and pure water were obtained, and the pollution of the soil was prevented, cholera would be entirely escaped. Dust-bins, dirty linen, unhealthy food, and personal uncleanness would all encourage and in fact lead to cholera. It was of vital importance to know that cholera was not a disease infective from person to person in a direct sense, as small-pox and some other diseases were, and this knowledge made the disease lose many of its terrors. The prevention of the cholera depended upon the public authorities acting with spirit and incurring the necessary expenditure upon making and keeping clear our soil and our water supply, and upon individuals exercising proper supervision over the households they could control, and the poor whom they could help. These things would rob cholera of all its terrors. It was no rash thing to say that if cholera did reach the metropolis or any town in this country, the authorities, the medical men, and the people generally were armed with so much knowledge, and had made such progress in the methods of defending themselves against it, that no such epidemic of cholera in the future as there had been in the past need be feared.

CANADA MEDICAL ASSOCIATION.—The sixteenth annual meeting of the Canada Medical Association

will be held in Queen's College, Kingston, commencing on Wednesday, the 5th of September, under the presidency of Dr. Mullin, of Hamilton. The committee of arrangements has made every provision for the comfort and convenience of members who will honor the "Limestone city" with their presence. A large meeting is confidently anticipated, and we trust our confrères in the western part of the Province, and from the entire country, will turn out in large numbers. Western members will reach most comfortably by taking the boat from Toronto on Tuesday, at 2 p.m. Return tickets will be issued by all railways at 1½ fare, and by the Intercolonial R. R. and Richelieu and Ontario Navigation Co. at one fare. Hotel accommodation in Kingston, from \$1.50 to \$2 per day. We give herewith a list of the papers to be read at the coming meeting, received up to the 25th ult. The secretary, Dr. Osler, Montreal, will be pleased to receive notice of papers to be read, up to the 4th inst.

Case of Chronic Suppuration, Dr. J. E. Graham, Toronto. Diet as a Therapeutic agent, Dr. Playter, Toronto. Fractures of the Forearm, Dr. McNaughton, Erin, Ont. Digitalis, Squill and Strychnine Combinations in Diseases of the Mucous Membranes, Dr. Kerr, Galt. Reminiscences of the Visitation to Canada of Asiatic Cholera, Dr. Workman, Toronto. Experiments in Resection of the Bowel, Dr. James Bell, Montreal. Retroversion and Retroflexion of the Uterus, Dr. Worthington, Clinton, Ont. Anomalous case of Femoral Hernia, Dr. Campbell, Seaforth, Ont. Paracentesis Pericardii, Dr. McDonald, Londonderry, N. S. Specimen of Gangrenous Intestine, Dr. Sheard, Toronto. Dropsy of the Amnion, Dr. Dorland, Milwaukee. Chronic Bright's Disease, Dr. Osler, Montreal. Papers have also been promised by Drs. Brouse, Gardner, Hingston and others.

ONTARIO MEDICAL ASSOCIATION.—The following are the names of the gentlemen forming the temporary committees nominated by the President, Dr. D. Clark :

MEDICINE.—*Chairman*, Dr. Harvey, Watford ; Drs. Hunt, Clarksburg ; Gillies, Teeswater ; Caw, Parkhill ; Beaton, Orillia ; Battersby, Port Dover ; Rae, Oshawa ; Nation, Uxbridge ; McTaggart, London ; Orr, Hastings ; Macdonald, Hamilton ; and Barrett, Geikie, Davidson, W. H. Aikins, Carson, McFarlane, Playter, O'Reilly, and Sheard, of Toronto.

SURGERY.—*Chairman*, Dr. Burt, Paris ; Drs. Campbell, Seaforth ; Street, London ; Christie, Flesherton ; Digby, Brantford ; Yeomans, Mount Forest ; McNaughton, Erin ; Hurlburt, Brucefield ; Dupuis, Kingston ; Bascom, Uxbridge ; Burrows, Lindsay ; McLean, Goderich ; and Drs. Fulton, Oldright, Aikins, Zimmerman, A. H. Wright, Thorburn, Wagner, and Burritt, of Toronto.

OBSTETRICS.—*Chairman*, D. J. Ross, Toronto ; Drs. Ghent, Priceville ; Bogart, Campbellford ; Groves, Fergus ; Hillary, Aurora ; Smith, Sparta ; Turver, Parkdale ; Sinclair, Paris ; Rosebrugh and Malloch, Hamilton ; Lovett, Ayr ; O'Gorman, Hastings ; McCrimmon, Lucknow ; Gould, King ; Freeman, Milton ; Baird, Pakenham ; Bray, Enfield ; Kitchen, St. George ; and Drs. Workman, H. H. Wright, Burns, Strange, Macdonald, and King, of Toronto.

OPHTHALMOLOGY AND OTOTOLOGY.—*Chairman*, Dr. Palmer, Toronto ; Drs. Freel, Stouffville ; Henderson, Kingston ; Hamilton, Port Hope ; O'Reilly, Fergus ; Powell, Edgar ; Stalker, Ripley ; McKechnie, Thorndale ; Mitchell, Enniskillen ; and Drs. Ryerson, Reeve, Rosebrugh, McPhedran, and Holmes, of Toronto.

NECROLOGY.—*Chairman*, Dr. Bryce, Toronto ; Drs. Lepper, Meaford ; Patterson, Markham ; Smith, Pyne, and Martin, Toronto ; Dickson, Day, Harrowsmith ; Webster, Norval ; Radford, Galt.

AUDIT.—*Chairman*, Dr. Elliott, Lindsay ; Drs. Armstrong, Markdale ; Irving, Kirkton ; Miller, Woodhill ; Robinson, Markham ; Stutt, W. Flamboro' ; Ward, Napanee ; Wilson, Richmond Hill ; and George Wright, Duncan, Sweetnam, Sinclair, Hunter, and Wallace, of Toronto.

PAPERS AND BUSINESS.—*Chairman*, Dr. Nevitt, Toronto ; Drs. McLean, London ; Hunter, Ballantrae ; Fairchild, Brantford ; Todd, Georgetown ; Wood, Delhi ; Thom, Streetsville ; Duncan, Thamesville ; Fraser, — ; and Drs. Canniff, Buchan, Riddel, Stark, and Ferguson, of Toronto.

ARRANGEMENTS.—*Chairman*, Dr. Mullin, Hamilton ; Drs. Case, Leslie, Philp, and Woolverton, of Hamilton ; Inksetter, Dundas ; and Vanderburgh, Merriton.

PERSONAL.—Dr. G. H. Burnham, who has been resident surgeon at Moorfields, London, Eng., during the past six years, has settled in Toronto. He makes a specialty of diseases of the eye, ear and throat. Although we appear to be pretty well supplied already, yet we welcome him to our city, and wish him every success.

Dr. D. Darrach, of Kensington, P. E. I., has retired from practice on account of ill-health, and has been succeeded by Dr. McNeill (McGill, '83).

We sincerely trust Dr. Darrach's health may shortly improve.

Dr. T. S. Covernton, of Winnipeg, left England on the 30th of July, on a voyage to Penang, Singapore, Shanghai, Amoy and Hong Kong. He expects to return in December.

Dr. Hamilton Meikle, son of Rev. Mr. Meikle, of Oakville, has successfully passed his examination as surgeon in the Royal Navy.

Dr. Thomas Gray, of Ontario, formerly of Brigus, N. F., has successfully passed his examination for the double qualification of L.R.C.P. and S., Edin.

Dr. Theophilus Parvin, of Indianapolis, has been elected Prof. of Obstetrics and Diseases of Women and Children at Jefferson Medical College, Philadelphia, in place of Dr. Ellerslie Wallace, resigned.

Dr. Phelan, of Kingston, has returned from the continent to resume his practice. While abroad he attended the Mater Misericordiæ Hospital at Dublin, the London Hospital, the Beaujon and Salpetrière in Paris, and the City Hospital at Brussels.

VICTORIA MEDICAL SCHOOL, MONTREAL.—This school which is in affiliation with Victoria College, Cobourg, has been in successful operation for several years; but a strong rivalry prevailed between her and the Laval University medical school. Instructions were issued by the authorities of the church that Laval should be supported. The professors and students of Victoria continued to act contrary to the spirit of the official declaration. An order was then issued to the sisters of Hotel Dieu to refuse admission to all professors and students, except those of Laval. The sisters appealed to Rome, and the professors to a committee of Provincial Bishops. The latter have decided that no Catholic can conscientiously form part of Victoria School or attend lectures there, and those who do so cannot be admitted to the sacrament of the church, and the former have been again ordered to close their doors to professors and students of Victoria. This mandate effectually disposes of the Victoria School of Medicine, which is much to be regretted, as the school was doing a good work and was besides a means of stimulating healthy rivalry in medical teaching.

Just as we go to press, we learn that a cablegram

has been received from the Pope, ordering the Victoria school to be carried on as usual for the present.

CANADIAN SANITARY ASSOCIATION.—The first meeting of the Canadian Sanitary Association will take place in Kingston on the 6th of September, immediately after the meeting of the Canada Medical Association. A provisional committee has been elected, with Dr. Playter, of Toronto, as Chairman, and F. N. Boxer, C.E., as Secretary. The object of the association may be briefly stated as follows: To promote sanitary education; obtain joint legislative action when necessary between the several governments; to prevent the spread of infectious diseases; to secure the mutual co-operation of the boards of health, and to publish in a sanitary journal lectures on the laws of physics, chemistry of sewage, water pollution, etc.

LEPROSY AT TRACADIE.—A party of New York physicians, consisting of Drs. Fox, Williams, Pardee, Crosby and others, recently visited Tracadie, New Brunswick, to study the cases of leprosy in the lazaretto. A report on this subject will be made to the New York Dermatological Association. Dr. Fox remained several days in the institution, in order to watch more closely the condition and habits of the patients, and the nature of the disease. We are pleased to learn that the disease is dying out at Tracadie. Five years ago there were 36 cases in the lazaretto, whereas at present there are only 24.

ACTION FOR ALLEGED SLANDER.—The proprietors of the Throat and Lung Institute have brought suits against Dr. McCammon, of Kingston, and Dr. Bray, of Chatham, members of the Ontario Medical Council, for having, it is alleged, spoken in debate of the plaintiffs as quacks, medical prostitutes, etc. Damages are claimed to the extent of \$10,000 against each of the defendants. Whether the cases do or do not come to a trial—they will serve in the meantime to advertise the "spirometer" men.

PREVENTION OF INFECTIOUS DISEASES.—The Manitoba Legislature, during the last session, passed a most stringent measure for the prevention of the spread of smallpox and other infectious diseases. The Manitoba *Free Press* gives a complete

digest of the new law in its issue for August 2nd and 3rd. From a perusal of these papers we are led to believe that the authorities have full power to ensure sanitation and effectually cope with epidemics. The want of such an enactment has been severely felt in that province, and the authorities and the public are to be congratulated upon the passage of the act.

BRITISH DIPLOMAS.—Dr. E. M. Hewish, of Toronto, has been admitted to the L.R.C.P. Edin. Drs. P. J. Strathy (Trinity College) and C. E. Cameron (McGill) were admitted to the M.R.C.S. Eng., on the 25th of July. Dr. J. S. Lathern has been admitted to the L.R.C.P. Lond. Drs. W. D. Oakley (McGill) and P. G. Meldrum (Toronto) passed the primary examination of the Royal College of Surgeons, Eng., in July last. Dr. W. F. Cleaver (Kingston) has been admitted to the L.R.C.P. Lond.

CARBOLIC ACID IN HYDROCELE.—A paper was read before the New Brunswick Medical Society, by Dr. Jonah, of Eastport, Me., in which he reported three cases of chronic hydrocele successfully treated by the injection of from 30 to 90 grains of crystallized carbolic acid dissolved in about ten per cent. of water. The plan he adopted is similar to that recommended by Dr. Levis, of Philadelphia, several years ago, and which was also successful in his hands.

ATROPINE IN MENINGITIS.—A writer in the *Atlantic Journal of Medicine* (a new aspirant for professional favor, by the way) recommends the use of atropine in the ordinary strength of 2 grs. to the ounce, two drops in each eye night and morning. It relieves the intense photophobia, quiets the restlessness, and has a soothing effect on the patient generally. It certainly seems worthy of trial in such cases.

THE ADMINISTRATION OF SANTONINE.—Dr. Lewin, of Berlin, states that santonine should be given in its least soluble form, as the desired effect is not a general, but a local one. He recommends the administration of it in some oil, such as coconut oil, olive oil, cod liver oil, or castor oil. Some of the æthereal oils, which are so destructive to the lower forms of animal life, would be suitable in this connection.

WOMEN'S MEDICAL COLLEGE, KINGSTON.—The following are the names of the Faculty :—Dr. M. Lavell, Obstetrics ; Dr. M. Sullivan, Surgery ; Dr. Garrett, Anatomy ; Dr. Oliver, Materia Medica ; Dr. Saunders, Medicine ; Dr. Fenwick, Medical Jurisprudence and Sanitary Science ; Dr. Phelan, Institutes of Medicine and Histology. Botany and Chemistry will be taught in Queen's College.

RESORCIN AS A DRESSING.—This new remedy promises to become not only the popular remedy for a number of ailments, but also to take the field as a dressing for chancres, chancroids, mucous patches, etc. It is said to be more efficient than iodoform, while it is free from the unpleasant odor of that drug. It may be applied in powder, or in twenty-five per cent. solution in water.

OBITUARIES.—The death of Dr. Joseph Bell of Edinburgh is announced in our British exchanges. The *Progrès Médical* also announces the death of Paul Dubois, of Paris. Prof. Pacini, of Florence, the discoverer of the corpuscle which bears his name, is dead. Dr. Jacob Mosher, of Albany, N. Y., died on the 13th ult.

RESIGNATIONS.—Dr. J. C. Dalton has resigned the chair of Physiology in the College of Physicians and Surgeons, New York, on account of ill health. Dr. J. A. Curtis is his successor.

Mr. Jonathan Hutchinson, F.R.S., has retired from the position of Senior Surgeon to the London Hospital, his term of office having expired.

INVESTIGATION OF CHOLERA.—Pasteur, at the head of a commission for the investigation of cholera, is about to start for Egypt. The following gentlemen accompany him : MM. Roux and Thuillier, of Pasteur's Laboratory ; Strauss, of the Faculté de Médecine, and Nolaco.

REMOVALS.—Dr. Orton, M.P., Fergus, has removed to Winnipeg. Dr. H. O'Keefe has removed to Minto, Dak. Dr. S. S. C. Phippen has removed to Owasso, Mich. Dr. Mattice, of Cornwall, has removed to Sioux Falls, Dak.

APPOINTMENTS.—Drs. F. W. Strange, Toronto, and F. W. Campbell, Montreal, have been appointed surgeons to the Militia Schools of Instruction in Ontario and Quebec respectively.

CORONER.—Dr. R. Lambert, of Windsor, Ont., has been appointed Coroner for the Co. of Essex.

Books and Pamphlets.

A TREATISE ON DISEASES OF THE EYE. By J. Soelberg Wells, F.R.C.S., King's College, London, &c., &c. Fourth American, from the third English edition, by Charles S. Bull, A.M., M.D., New York. Philadelphia: H. C. Lea's Son & Co. Toronto: Willing & Williamson.

The present work has undergone many changes and additions which were necessary to bring it up to the present state of knowledge on the subject. The size of the book, however, remains about the same. The section on membranous conjunctivitis, and purulent conjunctivitis of new-born infants is entirely new. A full description of Landolt's method of blepharoplasty is given in the chapter on diseases of the lids. Sattler's views upon the nature of trachoma have also been given in their appropriate place, but no mention has been made regarding the use of the jequirity bean in the treatment of trachoma and obstinate pannus, owing, the editor states, to the MSS. having been in type before the observations on this subject were published. A very interesting article on optic neuritis in intra-cranial disease, by Hughlings-Jackson, will be found in the chapter on diseases of the optic nerve. This edition has been rendered as complete as possible, and the editor appears to have bestowed great care in incorporating all the important facts elucidated by recent researches in this branch of medical science.

THE POPULAR SCIENCE MONTHLY for August, 1883. New York: D. Appleton & Co. \$5 per annum.

The August number is the most vigorous and brilliant of the year. Its most important article is the monopoly of the Bell Telephone Company. They say to the public: "We hold the patents of a new art; we have patented talking through a wire, and the courts pronounce our patents valid; now help yourselves!" But, if the statements in this article are true, the whole claim is now exploded, and nothing remains for the courts but to reverse their decisions, and make the telephone free to the world. The art of talking through a wire was invented first, not by Bell, but by Reis, of Germany, who devised every one of the contrivances now used, in their essential principle and working effect. There is a masterly article by W. D. Le Sueur on "The Anarchy of Modern Politics," that will be read with profound interest. An account is given by Professor Tindall of his experiments to ascertain the effect of atmospheric

moisture in restraining the radiation of heat from the earth's surface. Dr. Oswald continues his valuable papers on "The Remedies of Nature." Other articles of interest are on "The Geological Distribution of North American Forests," "Locusts as Food for Man," "The Chemistry of Cookery," "Technical Education," etc.

ANATOMY, DESCRIPTIVE AND SURGICAL. By Henry Gray, F.R.C.S., Eng., London. 10th edition, just published. Philadelphia: H. C. Lea's Son & Co. Toronto: N. Ure & Co.

It gives us much pleasure to acknowledge the receipt of this valuable standard work on anatomy. There is probably no medical text book which has been so extensively used as "Gray's Anatomy." For years it has been almost the only work on anatomy in use by medical students, and the appearance of a new edition will be hailed with delight. It is almost unnecessary to say that the present edition is up to the standard in every respect.

THE ESSENTIALS OF PATHOLOGY, by D. Tod Gilliam, M.D., Prof. of General Pathology and Physiology, Columbus Medical College, Ohio. Philadelphia: P. Blakiston, Son & Co. Toronto: Willing & Williamson.

We are pleased to have to hand the Essentials of Pathology, by Prof. Gilliam. After a careful perusal of its contents, we feel justified in saying that it fills a long-felt want in that it contains in a concise form all that is required of the ordinary student of the present day. The chapter on general and local death we are especially pleased with, in that it puts very clearly the close pathological associations of molecular and general death. We would also especially notice the chapter on the pathology of the blood, which is put in a very concise and excellent manner. For students and practitioners who have not the time to wade through the more exhaustive treatises upon pathology, this work is one we can highly recommend.

Births, Marriages and Deaths.

At Walkerton, Ont., on the 26th of July, Wm. J. Cooper, Barrister, of Portage la Prairie, to Minerva H., only daughter of the late Wm. Henderson, M.D., of Napier, and step-daughter of L. Sinclair, M.D., of Walkerton.

On the 20th ult., Norman McGregor, M.D., of Lucknow, aged 50 years.

On the 22nd ult., Dr. Edward Laberge, M.P.P., of St. Philomene, Que., aged 54 years.

THE CANADA LANCET,

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Original Communications.

REMINISCENCES OF ASIATIC CHOLERA IN CANADA.

BY JOSEPH WORKMAN, M.D., TORONTO.

The following details of the visitations of Asiatic cholera from its first appearance on this continent in 1832, up to its last arrival in 1866, have been hurriedly brought together, with the intention of presenting them to the Medical Association of Canada, during its session in September, at Kingston. Owing, however, to the too great length of the paper, despite my desire to compress the facts into more limited space, and to my present equivocal state of health, I have, with much reluctance, been constrained to deny myself the pleasure of taking part in the proceedings of the Association, and I cannot think of trespassing on the kindness of any professional friend to read the paper, as my representative, nor indeed am I free from the apprehension that it might exhaust the patience of the audience.

The parts relating to the cholera of 1832 and 1834, are drawn chiefly from the inaugural thesis presented by me to the Medical Faculty of McGill College, on the occasion of my graduation in the year 1835. I have no hesitation in pledging myself for the perfect accuracy of my notes, as they were written by me, from day to day, as the events occurred; I have also every reason to consider the subsequent details as quite truthful.

It is not the unanimous opinion of medical writers that the disease now known under the various names of Asiatic Cholera, Spasmodic Cholera, Malignant Cholera, and Cholera Asphyxia is a new disease. Hippocrates, Aritæus, Sydenham and Huxham, are said to have distinctly treated of this malady. We are told that in 1669 and 1676

it prevailed in London, and in 1730 and 1750 in Paris. In 1762 we are informed it raged extensively in Hindostan, and that in each successive season an epidemic, showing the principal characters of Asiatic Cholera, prevailed more or less epidemically throughout India. But we have no reliable records of its extensive prevalence before the year 1817. It is true, many have been inclined to believe that the terrible pestilences which the Indian historians have recorded as having made extensive devastations in that part of the world, at various periods, were no other than the disease in question; yet when we consider the vague and unscientific manner in which both historians in general, and some early medical writers were accustomed to describe diseases, we may feel inclined to question the identity of the disease now known as Asiatic Cholera with any of those recorded by writers of past times.

Asiatic Cholera presented itself in the year 1817, at Jessore, a large and populous town, about 80 miles north east of Calcutta, in that part of the province of Bengal, which is called the Sunderbunds or Lowlands, which constitute the extensive district lying between the numerous mouths of the river Ganges. It is stated to have appeared simultaneously at several other places in this part, and to have radiated into the surrounding districts. In July it reached Patna, on the Ganges, 300 miles north west of Calcutta. In the middle of August it appeared in Calcutta. In the month of November it carried off 5000 victims in the camp of the Indian army. During December it abated in every part of India; but in February 1818 it sprang up with renewed virulence, and assumed the dread character which it has ever since retained. Stretching towards the south it attained the southern extremity of Hindostan, and passed over to the adjacent island of Ceylon in December. In November of the following year, (1819) it was carried to Mauritius, and thence in January 1820 to the Isle of Bourbon. To the eastward we have it advancing with persistent pace, and devastating the populous countries in that direction, between the Altaian mountains on the north and New Holland on the south. It appeared in Arracan in 1818, in Java in 1819, Canton 1820, Pekin 1821, and in the island of Timor, which lies about 450 miles from the most north-western point of New Holland. To the west and northward we trace it

to Bombay in 1818; to Muscat, near the mouth of the Persian gulf, 1821. Passing up the gulf it visited the towns on each side. It reached the city of Bagdad in 1821, and before the end of 1823 it had reached Antioch and Diarbekir. During the winter it did not advance further westward; but from the north of Persia it passed to the borders of the Caspian sea; and in September 1823 it had reached Astrachan, near the mouth of the river Wolga. The cold of a northern winter seemed, at this time, to prove uncongenial to its existence, and the western nations were relieved from their apprehensions of its further progress. From this time till 1829, we know little of its movements; but it had never ceased to exist in Persia, where it prevailed yearly with more or less violence. In the summer of this year it raged with increased fury in the eastern provinces of Persia, and passing down the river Jihun (Oxus), and across the steppes of the Kirghis Kassaks, it reached the province of Ohrenburg, on the frontiers of Tartary in the month of August. It continued here until the following February, (1830), when it gradually subsided.

In the summer of 1830 it passed out of Persia in another direction; and skirting the western coast of the Caspian sea, we find it once more in Astrachan on 19th of July. From Astrachan it now passed up the Wolga, and by the middle of September it had reached the city of Moscow. In April 1831 it reached Warsaw, and in May it entered Riga and Dantzic on the Baltic. In June it reached St. Petersburg. We then trace it southward to Berlin in August, and to Vienna in September. In October it appeared in Hamburg, and near midwinter it crossed the German ocean to England, appearing first in Sunderland. From this starting point, despite the opposition of winter cold, it spread in various directions, and before the spring it had shown itself in all the principal towns of Great Britain; by the end of March it had crossed over to Ireland, and prevailed in Dublin. Early in April a vessel, named the "Carricks," sailed from Dublin, with 167 emigrants. Ten days after her departure one death took place, and during the succeeding fifteen days thirty-nine more were added. From this time up to the arrival of the vessel at Grosse Isle quarantine station, only five more deaths occurred. The captain reported to the boarding officer "forty-four deaths, by some

unknown disease." The real nature of this "unknown disease" no sane person now calls in question, nor indeed perhaps even then did any disinterested parties decline to admit it. The Carricks arrived at Grosse Isle on the 3rd of June (1832), and while anchored there a female passenger died after a three hours illness. On 7th of June a sailor died of cholera in a boarding house in Quebec; and on that evening the steamboat *Voyageur*, (not the *Swiftsure*, as stated recently by a writer in the *Mail*, for this steamer had then passed out of existence,) left Quebec for Montreal; but in consequence of being *overloaded* with emigrants, the captain was obliged to put back, and to disembark a number of them. Several of the disembarked were very soon after seized with cholera. The steamer proceeded on her way to Montreal; but before arriving at Three Rivers, an emigrant named Carr was taken ill, and he died before the vessel came into the port of Montreal. (Note.) Within the last four years I learned from the late John Carr, Harbour Master of Toronto, and for many years an alderman of the city, that the man Carr, here mentioned, was his brother. He came from the same Parish as myself, near to Belfast.) Another emigrant named McKee had been seized in the afternoon of the same day (June 9th); he was carried from the steamer into a tavern on the wharf. The dead body of Carr was exposed to public gaze during the next day (Sunday 10th), and, as I well know, was visited by many persons, from mere curiosity. Numbers also went into the tavern to see McKee—among others a soldier of the 15th Regiment, then stationed in Montreal. Cholera appeared in the barracks that night, and this soldier was its first victim.

On the night of Sunday, or the early morning of Monday, several cases appeared in various parts of the city. It was then for the first time I saw the disease, and it was impossible to avoid the conviction that it was new to Canada, though some physicians, for reasons best understood by them—

NOTE.—It was strenuously denied by the medical and other officers of the regiment, that this soldier had been near the dead, or the sick, emigrant, and my statement was questioned. It is, however, wonderful how tenacious of vitality fact sometimes is. Nearly 40 years after the death of this soldier, I was assured by Dr. Dewson of Windsor, who was son of an officer of the 15th, that the first cases of cholera in the Montreal barracks in 1832, were those of two soldiers who entered the tavern into which McKee was carried, and they assisted in rubbing him to ease the cramps. Dr. Dewson was then the pupil of the surgeon of the regiment.

selves, alleged that it was not new to them ; but we all have met with wise men whose brains are too densely packed with wondrous facts to leave any vacant space for the entrance of new ones. On the 11th several other cases occurred, and a continued increase took place until the 19th, when the pestilence seemed to have attained its acme. From Montreal I traced the disease along the travelling routes westward and southward. It appeared at Lachine on the 11th of June, among emigrants on their way to Upper Canada ; on 13th it was at the Cascades—the first case being that of a person newly arrived from Montreal. On the same day a boatman, direct from Montreal, died of cholera at Cornwall. On 16th it was at Prescott—the first cases were among persons just arrived from Montreal. On 19th a boatman from Montreal died of cholera at Brockville. On 20th it was at Kingston. On 21st the first decided cases occurred in York, (now Toronto.) On the 22nd a vessel from Kingston, called the “Massassauga Chief,” loaded with emigrants, arrived in the river below Niagara, but as there were several cases of cholera on board, the vessel was not permitted to come into port. Cholera did not at that time shew itself in Niagara.

Having thus followed the disease far enough westward, we may next endeavour to trace it towards the south. But on account of the obstacles offered to emigrants on the American frontiers, the progress of the disease in this direction was neither so regular nor so rapid as it was in passing up the St. Lawrence. We find it in Laprairie on 12th June, and in St. Johns on 14th. Straggling cases occurred in several places on the frontier ; but whether from the difficulty of ascertaining, or of writing, truth, the accounts of its appearance published were so confused and contradictory as to render it impossible to follow it with any degree of satisfaction. The disease was reported in New York on July 4th ; but some cases were said to have been observed previously—a very usual sort of afterthought with the *nil admirari* variety of observers. The first case in Philadelphia was by some stated to have occurred on 5th July ; but as a second one was not reported until the 14th, we may doubt the reality of that reported on the 5th ; for it would be an anomaly, perhaps never observed in the progress of cholera, that nine days should elapse from its arrival, in a large and populous city,

in the heat of July, without a second case soon following. From New York and Philadelphia the disease passed into various surrounding States, and before the close of the year it had traversed almost the entire face of the northern continent. In Montreal it continued to rage with terrifying virulence till the end of June. I remember one day on which the deaths exceeded 150. In the beginning of July it remitted in violence, but the scene of devastation was truly woful. Hundreds had been left without parents and without sustenance ; death had been in almost every house. No wonder that a beam of hope gladdened our sorrowing hearts, as we flattered ourselves that the fury of the storm was past. But we were doomed to sad disappointment, for before the middle of July the disease seemed to reawake with augmented vigour. Hitherto its victims had been principally from among the poor, and the upper ranks had flattered themselves on a happy exemption from its ravages ; by many of them the disease was spoken of as “*plebeian* in its habits.” They were mistaken—death’s carnival was not yet complete—his devastations now passed beyond the habitations of the poor and the houseless.

A remarkable instance of the transmission of the disease to the northward of Montreal, took place about this time. The settlement of New Glasgow, about 30 miles north west of the city, had imposed upon itself a sanitary cordon, and none of its residents ventured from home, until about the close of July, when a man named Young made the venture. On returning to his home he had much to tell of his city observances, and among his details he related the fact, that in the inn in which he lodged, he saw and rubbed a patient who was dying of the cholera, and he “was not a bit afraid of it.” Next day this brave man himself died of the disease. Two or three neighbours buried him quietly in his own garden. No other case in the settlement followed,—so much for prompt isolation.

After the beginning of September but few cases occurred in Montreal, yet one or two appeared so late as the end of October, and it was a somewhat strange fact that among the latest deaths was that of the undertaker who had cofined and conveyed to the graveyard nearly all the victims belonging to the protestant denominations. The apothecary and the matron of the General Hospital were both

carried off shortly after the casual admission of some cases into that institution,—on one of which the process of venous injection of a solution of muriate of soda was effected, with wondrous apparent benefit. The man seemed to revive as if by magic. Heat of body returned; the pulse resumed its normal force and rhythm; the husky voice gave place to distinct articulation, and all seemed to promise escape; but the illusion was soon dispelled,—the poor fellow died not many hours after.

It was in the midst of the July horrors that a very strange personage presented himself on the streets of Montreal, calling himself the "*Cholera Doctor*," and asserting his curative potency over the disease. His name was Stephen Ayres. He was attired in the grandeur of a scare-crow; his outer garment had once been a great coat; but it now seemed to be the relics of a dozen, the lacerated tails of which he had knotted into distinct hanks. He said he had come from the far west, expressly to do battle with the pestilence. To give prestige to his advent he was followed by an old brood mare, and she had a train of two colts of the respective ages of one and two years. Stephen went fearlessly into every part of the city, and he had many more followers than his three quadrupeds. I saw him, in rather a clouded aspect, at the bedside of the Hospital matron an hour or so before her death. He had administered to her his cure—all mixture of hog's lard and charcoal; but it did not save poor Mrs. Stevenson. Of course Stephen, like many another knight of the mortar, said he was not "called in time." He disappeared, but not as did the majority of his patients, for he was afterwards visible in other parts.

The total number of deaths in Montreal, from the incursion of the disease till its cessation, was upwards of 3,000. Of these, 2,000 were ascribed to the cholera, but as this calculation would assign 1,000 to all other diseases, for a period of, say, one-fourth of a year, and the whole population was then about 30,000, it is manifest that the proportion given to cholera was much too low. I feel satisfied that 2,500 to cholera, and 500 to all other diseases, would have been much nearer to the right mark. During the winter of 1832-33, cholera was followed by a very fatal form of typhus fever. Among its victims was Dr. Caldwell, and, I think, Dr. Vallee, and some medical students, as

well as two or three matrons of the General Hospital.

The second invasion of Canada by Asiatic cholera, took place in June, 1834, which was a month earlier in the season than the arrival of its predecessor. This disease was unquestionably introduced by emigrant vessels, and its movements were in complete accord with those of 1832. It was quite as virulent as the first pestilence, but it did not attack so large a number of persons. Perhaps this comparative immunity was explicable on the ground that the former so-called epidemic had cut off so many of the weakly and intemperate classes, and had thus deprived it of its favorite *pabulum*. It was, however, my belief, that much was due to the general entertainment of more rational views of the primary cause of the disease, as well as of its secondary or predisposing causes, to which countervailing agencies may, without doubt, be added the observance of wiser hygienic rules. In 1834 we saw none of the tom-foolery that was inculcated by the *savans* at the seat of government, such as burning of tar barrels and firing of cannon in the public streets. One hot Saturday afternoon, in 1832, St. Paul and Notre Dame streets were treated to a series of explosions of artificial thunder, whether with the view of driving away one fear by the substitution of another, must be best known to the instructing wiseacres. It certainly did no harm to the glaziers. One of the city physicians, in reply to the question from the seat of wisdom, "What result did you observe from the firing of cannon on the streets"? briefly and most truly answered, "much broken glass."

The total number of reported deaths from cholera in Montreal in 1834, was 1,200. The highest number in one day was 70.

Canada remained exempt from cholera from 1834 till 1849, a period of 17 years. This intervening period when compared with that between 1832 and 1834, is a pretty clear illustration of the absurdity of the doctrine which teaches us to expect recurrences of the malady at certain definite periods. The next invasion in 1854, was an additional proof of the fallacy; and if we add to these the fact of the possible existence of the disease in Ontario in 1866, which will be noticed further on, and its too probable future visitation in 1883 or '84, surely but very slight foundation can remain on which the cholera prophets may base

their predictions. It will come to us only when it is carried to us, and it is my belief that even then its progress may be stayed, or completely arrested, by prompt isolation of the first presenting case or cases. The converse of this was wofully demonstrated in Toronto in 1849. In that year I chanced to be chairman of the City Board of Health. During the spring, cholera was threading its way up the Mississippi. I felt assured it would in due course reach us, and I urged on my colleagues the necessity of preparing some edifice for the reception and isolation of the first cases. We were permitted to erect a wooden shed on the then totally vacant lot on which St. Andrew's market now stands. We flattered ourselves that we had done well, but a quarter of a dozen of lofty magnates residing in that region, thought otherwise, and they accordingly turned out one night and demolished our receiving-house. I appealed to my colleagues of the council, begging for the re-erection and future protection of our edifice. To my great chagrin I found that their sympathies were with the demolishers, whilst I came off with their contempt. I could see but one course open to me, and I took it. I resigned my seat as an alderman, and with that, of course, my place in the Board of Health.

The cholera reached Toronto early in June. The first reported case was in a house on Scott street, in the person of a man just arrived from Buffalo or Cincinnati. There was no place of isolation to which to remove the patient. The consequence was exactly what should have been anticipated. The disease spread, and in the course of three months it carried off more than 500 citizens, of whom several were of the respectable classes. The three demolishers however escaped, and no doubt they flattered themselves they had performed a very praiseworthy act; but many a bereaved wife and husband, and many a weeping orphan might have had just cause for ascribing their calamities to the selfish apathy of the west end demolishers. Poor things! they are all gone, but their evil deed should not be buried in their graves.

In 1851, the cholera, as appears from a report in the French language, written I presume by Dr. Tache in 1866, visited Quebec, having been brought in from the United States. It would appear to have lasted only five weeks, in September and October; but 206 deaths were ascribed to it. It did not reach Upper Canada at this time.

In November, 1852, a very formidable and fatal disease broke out in the Toronto Lunatic Asylum, which had some of the characteristics of Asiatic cholera. I understood however that Dr. Widmer regarded this disease as essentially different from Asiatic cholera, though not much less fatal. If Asiatic cholera be produced by filth, irrespective of specific infection, I might readily admit the possibility of its existence at that time in the Toronto Asylum. I had shortly afterwards the odoriferous task of cleansing the augean-stable-eclipsing mass of underlying abomination. Let any one try to imagine what must have been the hygienic condition of that edifice, nearly 600 feet in length, sitting over the accumulated dirty suds and kitchen dirtied water of four years contribution. Such was the fact, for the drains of the basement had never been connected with the main sewer running from the house to the lake. Fortunately the water-closets had independent connections of their own, else who will say how much worse the condition of the patients would have been? Will it be believed that a grand jury, presided over by a very magniloquent citizen, made a presentment within two months after the outbreak of the disease mentioned, in which they informed his lordship, the judge, and the public, that they had examined the water beneath the basement, and had found it clear and scentless. In the winter of 1853-54 I caused to be removed from this same basement some 200 cartloads of very rich manure. The directors of the asylum had, in the end of 1852, sent some samples of the air of various compartments to a distinguished chemist, who did not succeed in finding anything amiss in it. This may show how very undetectable dangerous gases may be, for during the cleansing process I had not less than 50 cases of erysipelas to fight against, and I cannot but believe the dirty state of the foundation had much to do with their causation. At all events I had no more of this trouble after the place was cleansed out, and proper attention to ventilation was given.

The cholera of 1854 was introduced into Canada by way of Quebec. It was brought by a ship from Liverpool, which reached the port on 17th of June. It appeared among emigrants at Montreal on the 22nd; at Kingston on the 25th, and on the same day, as reported, at Toronto. It continued till the middle of September. In my journal under date

11th August, I find the following entry :—" Up to the present time the health of the asylum has been excellent, though cholera has been prevailing in the city for at least seven weeks, and has carried off probably four or five hundred victims." That this exemption from the disease was largely attributable to the sanitary improvements previously effected, and to the hygienic regulations enforced under my direction, I would not dispute ; but at the time I placed my chief reliance on a stringent system of prohibition of city visitation by the servants of the establishment. An addition to the monthly wages was given to all who obeyed the instruction, and any one discovered to have disobeyed was forthwith discharged ; it was however very creditable to the service, that only in one instance was it necessary to enforce this penalty. The asylum continued free from the disease throughout the whole period of its prevalence in the city. The cholera shed was within a short distance of the boundary wall.

Toronto was exposed to another visitation of this disease in August, 1866, when a man arriving by rail from the United States, was found suffering under it. He was promptly removed to the General Hospital, where no doubt all proper precautions of isolation and disinfection were carried into effect. He had all the characteristic symptoms of Asiatic cholera, and he died within a few hours. It was reported that his nurse died of the disease a day or two after, but of this I had no certain information. A travelling companion of this man was stated to have died next day of cholera at Port Hope. Had the first case in 1854 been as promptly isolated as this was, who will assert that hundreds of valuable lives might not have been saved?

It seems to me a logical impossibility to study dispassionately the history of cholera visitations in Canada, and to reach any conclusion save one as to its mode of transmission from place to place, and its communication from person to person. The most strenuous advocate of the theory of contagion cannot however deny that the disease is discriminative in the selection of its victims, nor will he assert that its virulence and epidemic pervasion are not intensely aggravated by the disregard of sanitary and hygienic precautions ; but what have we ever learned, in the annals of the pestilence, that proves its transmission from coun-

try to country and town to town, without the intervention of human travel or traffic ?

It has kept pace with the march of armies, the advance of caravans, and the trail of Mahomedan pilgrimages ; it has threaded its way along the coasts of oceans and of inland seas, up or down the valleys of rivers, and along the lines of railways ; it has crossed oceans and high mountain chains, with winds abaft or ahead. It is a disease of man, and it follows man, or rather it keeps pace with him, go whither he may, when bearing with him its specific seed, dare I not now say, its special germ ? Who knows ? Let us await with becoming patience the result of the practical enquiries and personal observances of the pupils of that prince of etiological scrutinizers, the world-famed Pasteurs who are now pursuing their searches in the Delta of the Nile.

In the *Popular Science Monthly* for the present September, I have read, with much interest, a lecture on "*The Germ theory of Disease*," by Prof. H. Gradle, M.D., of Chicago, from which I quote the following passage :

" Thus exposed from all quarters to the attacks of these merciless invaders (bacteria, etc., etc.,) it seems almost strange that we can resist their attacks to the extent that we do. In fact, one of the arguments used against the germ theory—a weak one it is true—is, that while it explains why some fall victims to the germs, it does not explain why all others do not share their fate. If all of us are threatened alike by the invisible enemies in the air we breathe, how is it that so many escape ? If we expose a hundred flasks of meat-broth to the same atmosphere, they will all become tainted alike, and in the same time. But the animal body is not a dead soil in which bacteria can vegetate without disturbance. Though our blood and juices are the most perfect food the parasites require, and though the animal temperature gives them the best conditions of life, they must still struggle for their existence with the cells of the animal body. We do not yet know in what way our tissues defend themselves, but that they do resist, and often successfully, is an inevitable conclusion. We can show this resistance experimentally in some cases. The ordinary putrefaction—bacteria can thrive excellently in dead blood, but if injected into the living blood-vessels they speedily perish."

In the above lines there is much in small space

for sober reflection. We are at present only on the threshold of medical philosophy. Our greatest want is an accumulation of reliable facts, and our greatest evil in the past has been rapid and rash generalization from a too limited number of facts, and these too often of unreliable character.

PROGRESS IN OPHTHALMOLOGY.*

BY W. TOBIN, F.R.C.S., M.R.C.P.I., ETC., HALIFAX, N. S.
[Surgeon (retired) Army Medical Department].

GENTLEMEN,—Great as has been the progress in various branches of Medicine within the past half century, in none has it been more marked than in Ophthalmology, which bids fairly to be classed amongst the exact Sciences. Three great names are associated with this advance. That of Helmholtz, who by his marvellous invention, the Ophthalmoscope, has opened up the hidden depths of the eye for our inspection; that of Donders, whose great work on Refraction has reconstructed physiological optics on a mathematical basis; and that of Von Graefé, who has done for ocular surgery what the others have accomplished in less practical branches of the art.

Previous to the invention of the ophthalmoscope, under the mystifying names Amblyopia and Amaurosis, which my friend Landolt defines thus—"Amblyopia, where the patient sees nothing and the surgeon sees something; Amaurosis, where neither surgeon nor patient sees anything"—lay hidden diseases, which are now as patent to us as the noonday sun. The various affections of the lens, vitreous, choroid, retina and optic disk, have been recognized, classified and traced to their sources; some as purely local affections, others as manifestations of constitutional taints—such as syphilis, tubercle, rachitis, albuminuria and various affections of the brain or spinal cord. Since its invention, the instrument has undergone many changes. What a difference between the plane mirror of Coccius and the perfected ophthalmoscope in our hands to-day! The number of new patterns is simply infinite. Those of Loring and Cooper, Landolt and De Wecker are considered the best. I prefer one made by Ferriere, of Camberwell, a cheaper modification of which has been brought out by Mr. Jeuler, of St. Mary's Hospital. All,

in addition to the perforated, concave mirror, possess a set of refracting lenses (plus and minus) enclosed in a revolving disk. These lenses serve a double purpose. They enable us to examine the fundus, by the *direct* method, securing thereby a clearer and more highly magnified image than by the indirect; and at the same time, by their help, we can estimate the patient's refraction—thus abolishing the tedious test-type examination—which is found often, more especially in the case of children, misleading, if not impracticable. To estimate refraction by means of the ophthalmoscope, it is necessary to have the accommodation of both patient and surgeon in abeyance. This may be secured by atropine, or the use of a thoroughly darkened room on the one hand, but can be gained only by practice on the other. All errors, whether myopic, hypermetropic or astigmatic, may be noted and their amount estimated in this manner. I regret that I cannot go more into detail.

A new application of the mirror has been found in Keratotomy, a process of testing refraction, through the production of retinal shadows on the cornea. Light is reflected into the patient's eye, from the surgeon's perforated mirror, at a distance of one to three feet. The appearance and movements of the shadows produced, as they traverse the cornea, indicate the patient's refraction. Provided with a spectacle frame and a set of test lenses, we may correct, whilst in situ, any ametropic condition discovered. This process originated in the clinique of Dr. Galezowski, in Paris, and is now being extensively tested in the great ophthalmic hospital at Moorfields.

The use of the Perimeter has greatly assisted the ophthalmoscope in the physiological and clinical study of the human eye. By it we are enabled to map out the visual field and so determine any morbid changes in the retina. By visual field we mean all the space which vision embraces when directed towards one central object. The instrument consists essentially of an arc of a circle, of the value of a semi-circumference, is made of metal, and revolves upon a pivot. In turning, its apex describes a hemisphere, at the centre of which is found the eye under observation. The limits of the visual field are determined by moving white or colored disks, along the arc, adjusted to different meridians, till the object is perceived by

* Read before the N. S. Medical Society, June, 1883.

the patient. In this way we test the sensibility of the retina from periphery to centre. The result is a chart of the field of vision, which may be projected upon paper, and in which any deviations from the normal may be noted from day to day. The practical uses of the instrument are—to detect blind spots, technically called scotomata, in the retina. These may be due to hemorrhages, to syphilitic gummata, or other tumors; to detached retina, local nerve lesions and to various forms of choroidal and retinal disease. More especially is it useful in estimating functional changes originating either in the optic nerve or more remote nerve centres. In obscure cases of glaucoma, one of whose prodromata consists in a gradual narrowing of the visual field, its diagnostic assistance is invaluable.

But it is in the substitution of the metrical or dioptric system for the obsolete inch measurement, that Ophthalmology has had one of its greatest triumphs in the present day. So universal has this system now become, since its first suggestion to the profession, at the Heidelberg Ophthalmological Congress in 1875, that I can now only remember one oculist of eminence on the large staff at Moorfields who continues to work in inches. According to the old system, lenses were numbered by their focal length in inches. "Their refractive power being the reverse of their focal length was represented by a fraction, of which the numerator was 1, and the denominator was the focal length in inches. Thus, a lens of 6 inches focus, had a refracting power of $\frac{1}{6}$ th; that is to say, $\frac{1}{6}$ th the refracting power of a lens whose focal length was one inch." The latter was taken as the unit of measurement. Now the length of the inch varies in different countries, and all calculations by such a system had to be made in fractions; two difficulties, which were got over by substituting the diopter for the inch and the metrical system for the fractions. Nagel and Javal first proposed, at Heidelberg, the use of the metrical system in notation, and took as unit of measurement a lens having one metre focus. This unit is called a diopter, and becomes No. 1 in the new system. No. 2 is 2 diopters, is double the strength of No. 1, and has its focus at half a metre (50 centimetres). No. 10 is 10 diopters, has a strength ten times that of No. 1, and has its focus at one-tenth of a metre (10 centimetres) and so on.

We have now the advantage of making our calculations in whole numbers, and of being able to estimate without trouble the focal lengths of the lenses we employ. As all refraction ophthalmoscopes, test glasses and spectacles made in the old country are numbered according to the new system, it becomes imperative for the specialist and most useful for the general practitioner, to form an acquaintance with it.

No less important have been our gains of late years in the departments of Ocular Surgery and Therapeutics. Allow me, briefly, to allude to some of them. First, let me mention the modern treatment of Glaucoma, long looked upon as an incurable affection; now, thanks to the discovery of the prophylactic action of iridectomy in these cases, by Von Graefé, and to the equally if not more efficacious operation, termed Sclerotomy, by my master, De Wecker, brought within the range of practical surgery. The advantages and disadvantages of either operation were well discussed at the last meeting of the International Medical Congress in London. Further experience alone may decide which is to carry the palm.

While both equally reduce tension and relieve pain, iridectomy is objectionable on account of the deformity it occasions. Again, it is an operation which cannot be indefinitely repeated—in certain disorganized conditions of the iris it is impossible. Sclerotomy on the other hand (which consist essentially in an incision of the sclerotic involving the iridian angle, in the neighborhood of Schlem's canal, leaving behind a cicatrix, which is supposed to act as a permanent drain to the globe—Filtration Cicatrix, DeWecker terms it) may be repeated as required, produces no deformity, is applicable to more cases of the disease, and in exercised hands requires no greater skill for its performance. I have seen the operation repeatedly done by De Wecker, and have never witnessed the ill effects with which it is credited by certain English ophthalmologists.

The different methods of extracting senile cataract might form another interesting subject for discussion. I shall mention the one most in favor, as illustrating our progress in this direction. Such operations as couching, reclinacion and needling hard cataracts are now matters of-history. The modified linear operation, combined with an iridectomy, done upwards so as to secure protection

from the upper lid, is most in vogue both in Paris and London. Surgeons no longer seek "the maximum of linearity" insisted on by Von Graefé, and have transferred the incision from the sclerotic to confine it altogether to the corneal region. Though cosmetically not so perfect as the simple extraction (without iridectomy), if we look only to practical results, it is found to give the greater number of cures. What we are taught to seek in every modern extraction, are cleanliness of the wound, perfect adaptation of the flap, a corneal incision large enough to allow easy escape of the lens, and thorough evacuation of cortical matter. This is facilitated by the iridectomy, which lessens the danger of glaucomatous complications, and should always be insisted on in cases where the eye to be operated upon is hard to the touch. The use of antiseptic precautions in cataract extraction I have usually seen confined to a preliminary disinfection of hands, instruments and the ocular surface itself. Boracic and salicylic acids in combination, form the solution which De Wecker employs. He discards altogether the use of sponges in eye surgery, using absorbent, antiseptic cotton instead, which may be thrown aside as it is used. I have seen only one oculist operate under the spray; it is not used at Moorfields.

Amongst interesting eye operations, I have seen Mr. MacNamara extract the whole lens in its capsule at the Westminster Ophthalmic Hospital; and, whilst serving in the Indian Medical Department, he had, he tells me, many opportunities of performing the operation, with success, upon natives. The dangers of the operation, from the unavoidable loss of vitreous, are such that it has not become a favorite with specialists. To extract by this method, a broad keratome and a scoop are all that are required. The pupil should be first fully dilated with atropine. A broad incision is made with the keratome at the sclero-corneal border. Through this a scoop or cataract spoon is passed forward into the anterior chamber, till it rests on the margin of the lens. Rupturing by downward pressure the ciliary attachment of the capsule, the scoop is passed transversely behind the lens and withdraws it entire from the eye, enclosed in its capsule. The after results, when the operation succeeds, are very brilliant.

The use of Eserine in eye surgery should not be passed over without remark. This drug, sulphate

of eseria, the alkaloid of the Calabar bean, empirically introduced to the profession by Lagureur, has been found most useful in cases of acute and hæmorrhagic glaucoma, through its well-known effect in diminishing the calibre of blood-vessels, and diminishing secretion. In some cases it does away with any necessity for operation. In sclerotomy it is instilled before and after the operation; in cataract extractions it is usefully employed, to restore the iris to the proper position and prevent it becoming fixed in the angles of the wound. One or two drops suffice to produce myosis. Its action is not so permanent as that of its antagonist, (atropine). It is useful also in ulcers of the cornea.

Of all the apparently hopeless cases we meet with in eye practice, none seem more beyond our skill than cases of detached retina. Such detachments may be due to injury, myopic changes, increased fluidity of vitreous, or may be mechanically produced by effusion of fluid between the choroid and retinal coats. These detachments are easily recognized by the ophthalmoscope, and their extent may be mapped out with the perimenter. It is in the cases where the detachment has been mechanically brought about by effusion, that means have been taken for its relief.

Mackenzie, I believe, first recommended puncturing the sclerotic below the seat of detachment. Bowman followed, advising laceration of the detached retina, with two needles, as in the operation for secondary cataract, to allow the escape of the effused fluid into the vitreous. De Wecker endeavored to draw it off with a trocar and canula, and subsequently attempted to form a permanent drain, by inserting a gold wire through the sclerotic and allowing it to remain for some time in the eye. Finding none of these plans successful, he had returned to the simple puncture till lately, when I have seen him substitute the galvano-cautery needle for the knife, and with this puncture the sclerotic at the point of the detachment.

The operation is done thus: The patient being prepared as for cataract extraction, the operator seizes the conjunctiva and subconjunctival tissues with the forceps, near the inferior border of the cornea, and draws the globe forcibly upwards and inwards as far as it will go. A point is then selected free from vessels, and the needle heated to a white heat, is plunged between the external and inferior recti (or should the seat of detachment

indicate it, between the internal and inferior recti) through the sclerotic into the eye. It is not allowed to pass more than 4 or 5 millimetres. On its withdrawal, eserine is instilled and a compress and bandage applied. The patient is kept on his back in a darkened room for some days, the eresine being daily repeated. I have seen benefit result from this operation.

Amongst other novelties in modern eye surgery, I may mention the disguising of indelible leucomata of the cornea by tattooing the surface with Indian ink, an operation very easily performed, and producing the most wonderful change in the appearance of the patient. A very perfect imitation of the pupil may be produced in this way. It is also useful in diminishing the dazzling produced by an iridectomy done for prophylactic purposes elsewhere than under cover of the upper lid.

What bids fair to be another step in progress consists in the substitution of "ablation of the ciliary nerves" for enucleation in certain cases of sympathetic ophthalmia. Given a case where the sympathizing eye is going through all the distinctive phases of an Irido-choroiditis, and where the irritating eye still possesses a certain amount of vision, what is to be done? In the old days they would say enucleate, now we endeavour to preserve the irritating eye, but to put an end to the irritation by dividing the ciliary nerves in that section of the globe, where most irritation and tenderness exist. A section of the rectus tendon on that side will expose the posterior segment of the globe and the nerves which surround the optic may be snipped with a blunt-pointed scissors, care being taken to avoid damaging the great nerve itself. I regret that I have not been able to follow up the cases in which I have seen this operation performed.

Other matters which might be interesting, crop up as I go on, but time does not permit my dwelling upon them now; such as the various operations for conjunctival transplantation, the new treatment of that opprobrium of surgery, granular lids, by De Wecker, etc., etc.

It suffices if I have shown that, since its great revival 30 years ago, ophthalmogy has not relapsed into slumber, and that the great names of Helmholtz, Donders and Von Graefe, will not be the only ones to live in the memory of those who interest themselves in this branch of surgery.

IRREDUCIBLE FEMORAL HERNIA.

BY A. B. ATHERTON, M.D., L.R.C.P.&S., EDIN., FRED-ERICHTON, N. B.

E. M., æt. 44, female. Generally fairly healthy; has had some trouble with varicose veins and ulcers on leg. Femoral hernia appeared on right side six or seven years ago. During the last year she has had four or five attacks of strangulation, which were relieved after the return of a portion of hernia, chloroform being required more than once to assist in its reduction. There always remains a lump nearly as large as the fist, which is irreducible. Finally, she has become entirely incapacitated to do housework, as going about on foot gives rise to symptoms of strangulation. I may mention also, that just previous to menstruation and during the first day or so after it begins, she suffers a good deal of pain and soreness in the tumor, the pain running down the thigh. As she had become so unfit to do her ordinary duties as a housemaid, I advised an operation, and after some delay her consent was given.

Dec. 7, '81—Operation.—Chloroform given and assistance rendered by Drs. Coburn and Coulthard. A fold of skin was pinched up over the swelling and a bistoury run through it, making a vertical incision $2\frac{1}{2}$ or 3 inches in length. After getting through subcutaneous fat, the hernial sac was soon reached; this being opened, its contents were found to be omentum, with something firmly adhering to it, which proved on subsequent examination to be a diminutive ovary with Fallopian tube attached. After separating adhesions to sac, these could not be returned and were therefore excised, their neck being ligatured with catgut. Catgut being scarce, I then tied the neck of the sac with silk and cut away the portion outside of ligature. Finally, a wire suture was put through borders of saphenous opening and neck of sac and the wound in the skin brought together with wire also, a small drainage tube being inserted at its lower part. Operation was performed with Listerian precautions and dressing of carbolyzed gauze applied. One quarter of a grain of morphine was given hypodermically. Ordered bits of ice to suck and milk in small quantities; also a suppository, containing half a grain each of morphine and ext. belladonna, to be used *pro re nata*.

Dec. 8—9 a.m.—Passed a pretty comfortable night. Did not use suppository; vomited a little, and had some eructations of wind; pulse 84, temp. 100° F. As there was some blood stain on dressing, I changed it under carbolic spray, removing the drainage tube.

Dec. 9—9 a.m.—Two suppositories used since yesterday morning, for pain and soreness. Slept well most of the night; vomited once this morning; pulse 68, temp. 99.5° F.

Dec. 10—9 a.m.—Rested well, one suppository being used at bedtime. Not much vomiting and less eructation of wind. Takes very little nourishment and desires but little; pulse 72, temp. 99.4°.

Dec. 11—10 a.m.—One suppository last night. Rested well; pulse 76, temp. 100.2°. Complains of dressing feeling stiff and uncomfortable. I therefore changed it under spray; wound looks well; only slight stain on inside gauze.

Dec. 12.—Took a drachm and a half of paregoric last night instead of using suppository. No vomiting for the last two days; pulse 88, temp. 99.6°.

Dec. 14.—One and a half suppositories used since the 12th; pulse 88, temp. 100°.

Dec. 15—9 a.m.—Some pain in back last night; also a chocolate-colored discharge, amounting to about 3ss, came from vagina this morning; pulse 96, temp. 99.6°. 3.30 p.m.—pulse 96, temp. 101.4°. Not much pain complained of. Wound dressed; no discharge; no redness of skin, nor marked tenderness on palpation; an induration of deep tissues, about three inches in diameter, however, was felt in the region of the wound. Sutures removed. On examination per vaginam, I felt no marked induration of roof of vagina, nor was there noticed any want of mobility of the uterus. I did not however push my examination, but touched the parts cautiously, and some slight change from the normal condition of the parts may have been present without my observing it. On withdrawing fingers, I found them covered with a thick purulent fluid, which the nurse stated was exactly like what had been discharged previously. Ordered hot vaginal douches of carbolized water three or four times in twenty-four hours.

Dec. 16—9 a.m.—Rested fairly without opiate. Had a dejection this morning, being the first since operation; pulse 96, temp. 99.6°.

Dec. 18—9 a.m.—Not much discharge for last day or two from vagina; pulse 72, temp. normal.

Considerable discharge found on dressing, which was changed. Probe entered an inch in centre of wound. Discharge was of a thin dirty character, and the odor somewhat fecal. A small drainage tube put in.

Dec. 21.—Discharge from wound is growing much less; none from vagina. Bowels moved yesterday; appetite improving; temp. normal. Has been taking a quinine mixture for a few days.

Dec. 25.—A sinus still keeps open, at the bottom of which is felt the wire suture. I therefore with some difficulty removed it.

Dec. 30.—Still slight discharge; pulse 80, temp. 98.8°.

Jan. 15.—Doing well; has sat up more or less for a week. Only a superficial sore now, the sinus having closed.

Jan. 28.—Wound soundly healed. No impulse felt by me on coughing, though patient herself feels something "give" at the point of hernial opening. A soft, easy truss applied.

April 20, '83.—Patient has been doing general housework as a servant for the last year or more. Rupture gives her no trouble, though truss is still worn. On examination, I find a distinct impulse on coughing, but no protrusion of consequence occurs. She is very subject to coughs and colds, and has suffered several times pretty severely from them during the year.

REMARKS.—There are two or three points in the above case worthy of notice. First, the rather uncommon presence of an ovary in the hernial sac, and its removal along with the omentum. Secondly, the occurrence of suppuration in the deep parts of the wound and the discharge of pus through, I believe, the stump of the Fallopian tube into the uterus and hence into the vagina. Suppuration in this situation would probably much more likely occur on account of air entering through the uterus to that part of the wound, especially as three or four inches of Fallopian tube were removed with the ovary. I believe that, under the antiseptic precautions used, there would have otherwise been no suppuration at all.

Thirdly, we have the return of the hernia to a certain degree after its apparent cure. This is a result only too apt to follow some time after any operation for its radical cure. Many patients after Wood's operation, who have seemed thoroughly cured at the time, subsequently suffer from a re-

lapse. This has been told me by Mr. Wood himself, as well as by others who have frequently performed his operation. Besides, it is probable that the removal of the wire suture in my case helped to admit of the formation of another hernia. I had intended to leave the wire in the parts permanently, but suppuration having occurred, I feared lest it might not remain there quietly and therefore I removed it. It is very probable, also, that this operation of sewing up the hernial opening will prove more successful in obtaining a radical cure in cases of *inguinal* hernia, as the sides of the inguinal ring afford a better hold to the suture; and furthermore, there is more cellular tissue about it to aid by its thickening in closing the aperture. For these reasons Wood's operation proves more satisfactory in inguinal than in femoral hernia.

The other most fashionable operation at the present day for the radical cure, is the injection of a decoction of oak bark into and about the neck of the sac, so as to produce more or less inflammation and consequent deposit and organization of lymph, and thus close the opening. Which of the various operative procedures will prove best suited to fulfil its purpose, time must determine. In irreducible hernia, however, and in cases of strangulation in which a radical cure is attempted, there is of necessity none so suitable as that of suturing the sides of the ring, at the same time including the neck of the sac, and perhaps a stump of the omentum to assist in blocking up the hernial aperture.

REMARKABLE CASE OF OBSTETRICS— ABORTION AT TWO MONTHS AND QUADRUPLETS AT FULL TERM.

BY DRs. EDWARDS AND MCTAGGART, LONDON, ONT.

On the 21st of July of the present year we were called to see Mrs. S., of this city. Patient of small stature; English by birth; æt. 38; average weight, 100 lbs.; height, 5 feet, 1 inch. She is the mother of four living children, two boys and two girls—aged 12, 10, 8 and 7 years. There was nothing unusual at any of her previous confinements—never had an abortion before. On abdominal examination, we found the abdomen extremely enlarged and pendulous. We advised support

from the shoulders. She told us that she was but five months *enciente*; but from her history and condition we assured her that she was seven months pregnant. Patient always enjoyed good health; menses always regular. She last menstruated on Dec 4th, '82. About seven weeks from this time she commenced to flow, which lasted for some three weeks; this was accompanied with pain. With a pain somewhat resembling a labor pain, something was expelled, which she described "as a lump of flesh with bloodvessels in it." To this "lump" was attached a short "string." At this she became alarmed and consulted a medical man, who assured her that she had had a miscarriage. He prescribed some medicine, which he said would check the flow and remove anything that might remain. From her account, the flow increased for a few days, but finally stopped.

From this time until Friday, Sept. 14th, '83, she has been, comparatively speaking, quite well, although distressed by the immense size and weight of the abdomen. On the above mentioned date she was delivered of four living children—two boys and two girls, the time elapsing between the birth of the first and birth of the last child being one hour and forty-five minutes. The weight of the male children exceeded that of the females by a few ounces, the weight of the males being 4 lbs. 9¼ oz. and 4 lbs. 3 oz., and that of the females 4 lbs. 6 oz. and 3 lbs. 13¾ oz. Labor terminated favorably, there being no hæmorrhage to speak of. There was but one placenta, and each cord was inserted at different places on its surface.

The quartette are now six days old, all healthy and able to nurse, and all bid fair to live. The mother is doing exceedingly well, having suffered no more exhaustion than if she had had but one child. We might here say that the father, Mr. C. S., is English by birth, æt. 41, height 5 feet 5 inches, and average weight 169 lbs., is a strong, healthy and robust man.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—As the accompanying communication, addressed by me to the editor of the *Medical Times and Gazette*, may be regarded as an "open letter," may I ask the favour of its presentation in your

pages. It is very improbable that the *Medical Times and Gazette* will award to it the requisite space for its appearance uncurtailed, if at all. I am not however anxious as to the impression made by the criticism of the *Medical Times and Gazette* on the other side of the Atlantic, but as many of your subscribers no doubt read this British journal, I deem it but just to them, and due to myself, to afford them the means of judging fairly of the grounds on which its editor rested his criticism of my translation of Professor Golgis' very important work.

Respectfully yours, &c.,

JOSEPH WORKMAN.

Toronto, Sept. 15, 1883.

To the Editor of the Medical Times and Gazette.

SIR,—A professional friend has placed in my hands your number for July 14th, in which, at page 54, in your notice of the April number of the "Alienist and Neurologist," you have alluded in rather severe terms to my translation of Professor Golgis' memoir on the minute anatomy of the central nervous system. I am hardly surprised that my rendering of Prof. Golgis' excellent work has evoked your displeasure, because of my too close adherence to the text of the author, for in truth I have, since the appearance of my translation in print, been myself dissatisfied with it, and I feel grateful to you that you have been so merciful as to ascribe its defects to my "ignorance," rather than to my ignorance of "the structure of the English language."

Presuming, as from your allusion to my "anxiety to produce a literal transcript of the author's words," (an impeachment whose justice I most frankly admit, for I think that in works of science this is always the safest and most just rule), I am warranted in doing, that your knowledge of the Italian language enables you to speak authoritatively in this matter, I may with fair expectation of some mitigation of your censure, appeal to your candour as to the great difficulty, or indeed, in numerous instances, the extreme perplexity encountered by English scholars, in reducing into decent English verbal order, long and complex, and sometimes even simple Italian sentences, for as you must well know, our greatest embarrassment is not in lighting upon the equivalent English words, (though even this is sometimes unattainable), but in arranging them in that order of relation and sequence, which best accords with that of our own less systematic idiom. I freely admit my defects in this relation, but I trust you will not be so harsh as to disregard my appeal to your English manliness, when I tell you that the state of my constitutional powers, now that I am on the verge of four

score years, did not permit of my writing out a second or revised copy of my version, which went to the printer just as it had been thrown off, *currente calamo*, and you must well know that nothing less than a patient and studious revision could have enabled me to turn out my work in passable English garb; indeed, I hesitate not to confess that I might have failed in pleasing even myself with only this amount of emendation, and how much more certainly must I have failed in securing your eminent approval! I must, however, with all becoming deference to your conceded high authority, demur to your charge of unintelligibility, especially as illustrated by your citation of the Alienist's outlandish phrase, "complècate nervous anastomose." Might you not, without any perilous overstretch of charity towards me, or risk of injustice to the printer, have reasonably added this blunder to the others which you have justly attributed to him, or his proof-reader? To have so done would really have been giving the devil his due. I cannot better convince you of this than by enclosing in this letter the veritable lines of my M.S. in which the true words occur. You will thus see that I never wrote either *complècate* or *anastomose*, and you will further see that the printer has split up my sentence and made two where I had only one,—nay, even worse, he has commenced a distinct *paragraph* with the unwarrantable doubling of the word *anastomoses*, which you will see was plainly written both at the bottom of my page 22, (as has, for additional security of proper sequence, been my invariable rule), and at the top of page 23, with a small *a*, and was followed by a very plain comma.

The following is a transcription of the lines above mentioned, enclosed in my letter to the editor of the *Medical Times and Gazette*:—"Above all, for the reflex phenomena, it appeared to be a quasi absolute necessity to admit complicate nervous anastomoses

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anastomoses, which, indeed, had been already admitted, before histologists, by means of particular minute researches, engaged in the work of verifying their real existence."

Now, when you had under your eyes such a crowd of blunders palpably ascribable to the printer, might not the very apposition here apparent in the repetition of the word, in its true form, have averted the causticity of your criticism, as well as have delivered you from the temptation of indulging in that ill-disguised sneer at "good American"?

I "must protest" against this unbecoming national haughtiness, for though not, either by birth or residence an American, I have learned to hold in high esteem both the nation and its literature. I can now still less reluctantly than before admit the pertinence of the following distich, which I

recently found in a very clever poem by an English writer, who had travelled much, and had resided long abroad :

"All that's not English in *our* eyes
Is something to sneer at, and jeer and despise."

But now that I have said so much in self-vindication, both honour and honesty prescribe to me the duty of relieving the printer from blame with regard to the word "dicotomically." You very properly supply the correct word "dichotomously." If you will be so good as to turn to Golgis' article in the *Rivista Sperimentale*, you will see that on page 178, anno viii, the Italian word used by him is "*dicotomicamente*." Whether my transformation of Golgis' last four syllables into my three—mi-cally—was the result of ignorance, haste, or unconscious cerebration, I cannot now venture to say. We are all liable to be led by the nose, and perhaps some still more by the eyes. You move along docilely in Grecian fealty; I have fallen into Italian servilism; still my deviation from classic propriety has not, I believe, resulted in obscuring the sense of the author. We have a goodly assortment of English adverbs terminating similarly, and as I believe, without violence to etymological propriety. Besides, I had not to fear that I was writing for a people who require the aid of a cold chisel to get a thing into their heads. Americans are wonderfully shrewd *guessers*. Most truthfully I can say I never dreamed that the editor of the *Medical Times and Gazette* would condescend to notice anything coming from a rude Canadian.

But, you will ask me, what of that omitted h? Do not be too exactive. My paternal forebearers were English, and you, I doubt not, are so far a Darwinite as to believe in *atavism*, consequently you will admit that I may sometimes be oblivious as to the claims of this sadly maltreated aspirate; your cockney brethren take all sorts of liberties with it, killing it where it should be allowed to breathe, and dragging it from its slumber to the front, where not only should its absence be excused, but its presence sternly prohibited. You must, as an Italian scholar, admit that the people of the old peninsula have been ten thousand times more merciful than your brethren, for, as a living *sound* they utterly repudiate it; and so in truth do you in "dichotomous"; I bet you do not pronounce that ch, (which in truth should be gh), as the Greeks did their x; or if you do sound it as they did, then I shall know where to locate your nativity. The Italians do not, however, as you know, repudiate the character. They make a very good use of its preserved bones, as a stiffening to their c and g, when these letters might otherwise fall into a limpness out of accord with their radical vocal identity. In this they very closely resemble your War Department, which, on certain occasions, when some nobodies "blundered," called on Hibernian generals to give firmness, pluck and dash

to your armies; witness Arthur Wellesley and Garnet Wolsley.

I must now entreat your pardon for so long a trespass on your valuable time, and so trying an exercise of your patience. Pray do not for a moment suppose that I shall look for any *amende*. Forgiveness is the Christian duty of the injured; the injurer cannot forgive.

I have the honor to be,
Your instructed reader,
JOSEPH WORKMAN, M.D.

P.S.—If you have chanced to see in the July issue of the *Alienist and Neurologist*, a translation (so called) of certain "conclusions" of Binachi, pray heap not Ossa upon Pelion, by deeming me the perpetrator.
J. W.

(To the Editor of the CANADA LANCET).

SIR,—In the announcement of the Toronto School of Medicine for 1883-84 the following statement appears: "The students of the Toronto School of Medicine have always taken a high standing at the various examinations they have been called on to undergo; and at the examinations in 1883 of the Toronto University, where they met in friendly competition the students from all affiliated institutions, they succeeded in obtaining five scholarships out of six, all the medals, and one hundred and twenty honors, out of a total of one hundred and fifty-six which appeared on the class lists."

This is a most unfair and unwarranted representation, for before such a statement of comparative merits as the foregoing can be made the conditions must be the same, *first*, with respect to the number of candidates from each of the affiliated schools; *second*, with regard to the number of competitors from the affiliated schools in each of the examinations included in the result stated, and, *third*, with regard to the relation each of the schools stands to the examiners.

With respect to the first point, instead of there being an equal number of candidates from each of the schools taking the first, second, third and fourth year's examinations, three-fourths of the total number were from the Toronto School of Medicine and only one-fourth from "all other affiliated institutions." Hence it follows that the Toronto School must win three-fourths of the honors before they could claim anything more than equality. They however leave the reader to

infer that what their students won in excess of "all other affiliated institutions," was due to superior training.

2nd. In the fourth year's examination there were no candidates except from the Toronto School of Medicine, and as only fourth year candidates are eligible for medals, it is therefore not true, as implied in the statement, that the Toronto School students met in friendly competition the students from "all affiliated institutions" and obtained all the medals. In 1822, the students of the Toronto School did meet in friendly competition students of another school in the fourth year's examination, with the result that the Toronto School students did not obtain either of the two gold medals.

3rd. In the first and second year's examination, the examiner on Anatomy was a lecturer on that subject in the Toronto School of Medicine; and in the first year, the examiner on Biology and Comparative Anatomy was also the teacher of those branches in the same school; so that the students of the Toronto School of Medicine had the advantage over all others, of being examined by two of their teachers on the subjects they teach, and the students of other affiliated institutions labored under the disadvantage of being examined in these branches by the teachers in a rival school. This is not to be understood as a charge of partiality against these examiners, for the candidates are not known by name; but it is a fact well known to those who have experience in teaching, that pupils will make a higher percentage on any subject when examined by their teacher than when examined by a stranger.

Enough has been stated to prove the unfairness and untruthfulness of the statement referred to. There is, however, another feature of this "college announcement" which I wish to allude to, as it appears to me to be a very striking instance of "professional advertising." By way of contrast, compare the following examples of the "puff direct."

I. Dr. M. Souvielle, of Paris, founder of the celebrated International Throat and Lung Institute, during his late visit to London, Paris and Berlin, secured the services of a number of eminent specialists, to assist in his present great work. Thousands of cases even in advanced stages of catarrh, bronchitis, asthma and consumption are

being cured yearly by these specialists, etc. *Case.* F. C., consulted several well-known physicians, but received no benefit. He finally came to the above Institution and was cured in three weeks. (*Advt.*)

II. Ontario Pulmonary Institute, M. Hilton Williams, M.D., M. C. P. & S. O., Proprietor. "Permanently established for the cure of all diseases of the head, throat and chest, including catarrh, bronchitis, asthma, consumption, etc., etc. During the past eighteen years we have treated over 40,000 cases of head, throat and lung troubles." (*Advt.*)

III. "The students of the Toronto School of Medicine have always taken a high standing at the various examinations they have been called on to undergo; and at the examinations in 1883, of the Toronto University, where they met in friendly competition the students from all affiliated institutions, they succeeded in obtaining five scholarships out of six, all the medals, and one hundred and twenty honors out of one hundred and fifty-six which appeared on the class lists." (Announcement of the Toronto School of Medicine.)

Of the three examples the last one is the most glaring, coming as it does from the Faculty of the oldest Medical School in the Province. If those who have the training of medical men can set such an example with impunity, why ostracize individual members of the profession for vaunting their skill and cures in the press or in circulars.

Yours, etc., PRACTITIONER.

LONDON, Sept. 15th, 1883.

To the Editor of the Canada Lancet.

SIR,—No doubt your subscribers are aware of the action-at-law for \$10,000 damages which the Spirometer men contemplate against two of the most valuable and energetic members of the Medical Council, for language used while discussing one of the various subjects coming under their jurisdiction as our medico-legal councillors. I venture to express the hope that, inasmuch as these gentlemen give their time and services gratuitously year by year, for the benefit of the general profession; and as it is clearly the "free advertising" the concern is after by such a move, their defence will be provided for from the funds contributed by the general profession to the Council.

It is also to be hoped that, when one or two of their brethren are attacked, the other councillors, whose sentiments and opinions these gentlemen so plainly and emphatically uttered, will have the manliness to stand up and support them, as is their duty, and not raise up earthworks of trifling technicalities behind which to entrench themselves. We can assure such gentlemen that their actions will be very easily given their proper value by their supporters in the profession. I write this latter part, having to my surprise heard of a "weak brother" to-day.

Yours, etc.,

CONC. CRESC.

Toronto, Sept. 7th, '83.

Reports of Societies.

CANADA MEDICAL ASSOCIATION.

(Held in Kingston, Sept. 5th, 6th and 7th, '83).

The sixteenth annual meeting of the Canada Medical Association took place in Kingston on the 5th, 6th and 7th ult., under the presidency of Dr. Mullin, of Hamilton. In the absence of the Treasurer, Dr. Sheard was appointed in his stead. The Association was welcomed by the Mayor of Kingston on behalf of the city, Prof. Williamson on behalf of Queen's College, and Dr. Sullivan on behalf of the profession. The following delegates and visitors were invited to the platform: Dr. Hunt, Pontiac, Mich.; Dr. Walker, Detroit; Dr. McLean, Ann Arbor, Mich., and Dr. Dorland, Milwaukee; also ex-presidents and vice-presidents of the Association. After routine, the reports of committees were called for.

Dr. Canniff, chairman of the committee on "Sanitation and Vital Statistics," reported that the committee had not met because, as chairman, he had been frustrated in continuing the efforts by which the Medical Association had succeeded in inducing the Government to grant a sum of money for the purpose named. While he was kept in ignorance of the steps that were being made to confer with the Government, other Toronto men were appointed, and, only on explaining the relationship of Dr. Canniff in attempting to secure a Government grant was he placed on the deputation.

Explanations were made by Dr. Playter and Dr.

Larocque. They said there had been no intention to ignore the committee. The report was adopted.

Dr. Larocque, of Montreal, presented the report of the committee on "Climatology and Public Health." The report exhaustively discussed the best means of protecting the public health. The report was received and a vote of thanks accorded to Dr. Larocque.

Drs. Botsford, Fenwick, Grant, Graham, Rodger, Bray, Worthington, Malloch, Oliver, Tye, Sweetland, Canniff, Oldright, Yeomans and the President were appointed the Nominating Committee.

Dr. Metcalf invited the Association to visit the Asylum, at their convenience.

In the afternoon session the President delivered his address, of which the following is an abstract. He thanked the members for electing him to the high position. The honor might have justly passed to others, but as he had been elected he would do all in his power to discharge the duties. He referred in feeling terms to the demise of Dr. David, of Montreal, Dr. Campbell, of Montreal, and Dr. Thomas Watson. Some had thought the itinerancy system was opposed to the Association's usefulness, but he held that advantages had been derived from every place where they had met. They met now in this old city, the very cradle of civilization of the Western section. Every member recognizes that the institutions of this city remain worthy of Eastern Ontario and exercise their influences over the youth of the present with increased vigor corresponding to the growth of the country. He then alluded to some of the investigations recently made respecting the influence of minute organisms in causing disease. Lister stands foremost in advancing this branch of professional knowledge. His antiseptic method of treatment may not be, and indeed is not considered by himself an ultimate result beyond which it is impossible to pass, but the great merit of his work is, he first called attention to the agencies which effect the decomposition of organic substances. The modern treatment of wounds shows the pressing importance not only of preventing decomposition, but of recognizing what are its causes. Many successful practitioners agree with Dr. Gamgee, who says, "That he has never been troubled with the idea that infection is always floating in the atmosphere, ready to settle in the shape of impalpable and implacable germs into any breach which may be made in the surface of a living body, and that he believes life to be the great antiseptic."

As regards the practice of medicine, it is an important though difficult question to determine to what extent vegetable forms operate in the production of ordinary fevers. Dr. Murchison, in '75, at

the Pathological Society, pointed out a chemical process having resemblances to the multiplication of contagion. Several fermentations are recognized to be due to the growth of distinct vegetable forms. May not decayed or changed albuminous compounds act as similar ferments when introduced into the fluids of the body? Fever producing agents, it is now well recognized, find a ready vehicle in water, but the separation of the active agent from the liquid is difficult, though recent experiments seem to show not impossible. Dr. Burdon Sanderson, by precipitating with alcohol and then extracting with water, obtained an extract which caused fever. He has ascertained that no animal poison is really soluble, and adopts a plan of filtering through porcelain, by which a filtrate is obtained that does not produce fever. The first filtrate has no bacteria, but particles are seen in it. An hour after, bacteria are found in considerable numbers. The filtrate through porcelain shows no bacteria, and twenty-four hours afterwards remains barren. Now here the natural inference is, that the fever producing agents are to be found in particles, and yet it is possible that an animal fluid in passing through the fine cells of porcelain may be chemically changed and that the absence of fever-producing energy is due to this change. It is well understood that all bacteria found in diseased tissues are not to be regarded as causes of disease. When an animal fluid begins to decompose bacteria are seen, and the forms of vegetable life which appear depend upon the composition of the fluid. One specimen of urine will show the bacterium termo; if sugar be present, the torula cerevisiæ also appear. In other specimens small round cells appear, sometimes isolated, at other times in chains. So also it is probable that, according to the tissue decomposing, different forms of bacteria are present, each form as it were choosing that tissue most suitable for its growth. Hence, even if after death bacteria are found in any tissue, they cannot at once be regarded as causes of disease. It may be that in the dying body, the bacteria infesting the surface of the body and mucous-lining of the intestines in innumerable multitudes, may pass inwards to lay hold of the elements that are dead before the life of the whole body has ceased. This may serve to explain how it is that in different diseases similar forms of bacteria appear. It has been suggested that after all the diversity which is seen in fevers, several may depend upon the same bacteria, modified in the course of time with the circumstances of its growth. Dr. Ogston has unquestionably shown that in cases of acute suppuration attended with fever, certain forms of micrococci are invariably present. He found that micrococci taken from an acute abscess and carefully transferred to the albumen of an ordinary fresh egg reproduced themselves in myriads. He also found that if the minutest portion

of this albumen were injected under the skin of a healthy animal, similar abscesses resulted, abounding with micrococci. Ogston's experiments prepare us to receive the recent teaching regarding the cause of tubercular disease. This disease brings with it conditions favorable to the growth of bacteria, for parasitic growths are known to flourish in weak organisms. The breaking up of tissues incident to this disease also furnishes most fertile soil for the growth of bacteria. It may be true, as affirmed, that the bacillus is invariably present in cases of tubercle. This the above considerations would lead us to expect, without looking to it as the sole cause of the disease.

Many questions respecting these minute organisms and their influence in life and disease are still to be settled, but their study has unquestionably led to much improvement in the practice of the healing art. Our efforts to combat disease must to a very great extent depend upon our success in teaching the public to rely less upon antidotes and more upon those means which tend to build up strong bodies capable of resisting the agencies causing disease.

Dr. Tye, of Chatham, was appointed chairman of the surgical section, Dr. Gardner, of Montreal, secretary; and Dr. Graham, of Toronto, chairman of the medical section, and Dr. McDonald, of Montreal, secretary. The meeting then divided into sections.

MEDICAL SECTION.

Dr. Graham in the chair.

Dr. Playter read a paper on "Diet as a Therapeutic Agent." He thought a very large proportion of the cases of sickness which engage the attention of physicians is caused by errors in diet; especially were diseases of the digestive organs, liver, and kidneys and also the gouty and rheumatic diathesis thus caused. Such diseases, though, enrich the quack more than the regular physician. He would enquire very closely into the usual diet of all such patients and often a radical change in diet is a sufficient remedy.

Dr. Reeve, of Toronto, said he believed many cases of phlyctenular ophthalmia in children were caused by overeating of fresh fruit.

Dr. Graham referred to the influence of food in skin affections, acute attacks depending frequently upon peculiar sorts of food, and chronic cases upon either a defective or excessive diet.

Dr. Grant, of Ottawa, urged the importance of combining massage with regulation of diet.

Dr. Sheard, of Toronto, exhibited a specimen of "Invaginated and Gangrenous Bowel." The patient, a man aged 37, had a right inguinal hernia, with symptoms of obstruction. Hernia was reduced without much difficulty, but the symptoms of obstruction continuing and becoming urgent, Dr. Burns opened the abdomen, and found the tumor to be an invagination of the ileum into the

large bowel, which could not be reduced. On opening the cæcum, about seven inches of gangrenous bowel was found. The hernia was entirely omental, and not in any way connected with the obstruction. The gangrenous bowel was drawn through the opening in the abdomen and secured there. Patient died of shock in a few hours. Dr. Sheard considered this a suitable case for excision of the strangulated portion of bowel.

Dr. Osler said recovery sometimes took place by the sloughing of the piece of small bowel invaginated.

Dr. Mullin said that in cases of obstruction from any cause, he would treat the acute symptoms in preference to operating.

Dr. Botsford, of St. John, N.B., read a short paper on "Inflation of the Lungs by Abdominal and Thoracic Traction." His method was to draw the abdominal walls forwards, by means of pieces of plaster 4x4, thus leaving a vacuum which would be filled by air entering the lungs. Had not tried it practically, but thought it would be useful in chloroform accidents, drowning etc.

Dr. Mullin thought valuable time might be lost, and preferred the old methods of artificial respiration.

Dr. Burnham, of Toronto, had given anæsthetics in the Royal Ophthalmic Hospital in a great many cases and never saw a death. In cases of accident always relied on artificial respiration, with inhalation of nitrite of amyl.

Dr. Grant said that in a recent case he lowered the head with good results.

Dr. Dorland, of Milwaukee, read a paper on "Successive Dropsies of Amnion always Specific." He gave the history of six women he had attended who had suffered from this affection. In all, evidence of syphilis could be obtained. In some of the cases specific treatment succeeded in preventing this condition in subsequent pregnancies. He had some of the patients under his observation for years.

Dr. Mullin narrated a case in which, with a syphilitic child, the amount of liquor amnii was very large. Dr. Yeomans and others mentioned instances in which there was no suspicion of syphilis.

Dr. Dupuis, of Kingston, read a paper on the "Relation of Medical Men to each other, and to each other's Patients," which was largely a plea for no code in medicine. He did not approve of the new comers calling on those already settled in the place, and favored holding the consultation in presence of the patient and his friends. He considered it proper to give an opinion concerning the patient of another practitioner without consulting with him. He would take all the cases he could get without reference to previous attendant. To report cases of operation or extraordinary cures

in the papers was, he thought, quite justifiable, as he considered it different from advertising. Medical men should report their cases as well as the lawyer his speeches, or the clergyman his sermons.

Dr. Harrison, of Selkirk, Dr. Canniff, of Toronto, and Drs. McCammon and Oliver, of Kingston, disapproved of the opinions expressed by Dr. Dupuis.

Dr. Metcalf read a paper on "Hyoscyamine in the Treatment of Mental Diseases." He gave the results of six years' experience with the drug in the Kingston Asylum. He used Merck's crystalline preparation hypodermically in from one-twelfth to one-eighth of a grain. It was prompt and efficacious, and no ill-effects had followed its use in sixty cases. It was especially advantageous in all forms of maniacal excitement. If after a few doses no benefit followed, the drug was discontinued.

Dr. Hurd, of Pontiac, corroborated Dr. Metcalf's opinions.

Dr. Daniel Clarke, of the Toronto Asylum, recommended the drug in cases of delirium tremens, acute mania, and melancholia with suicidal tendency. He used Merck's preparation, and also the tincture (B. P.), as much as one and a half ounces. He had found the greatest benefit in acute mania.

Dr. Thorburn, of Toronto, suggested caution in the use of large doses.

Dr. Troutman, of New York, placed great reliance on the drug, but thought it was contra-indicated in acute delirium with dryness of tongue and muscular tremors; also in general paresis.

Dr. Graham, of Toronto, read a paper on "Leprosy in New Brunswick." The inhabitants in this region, chiefly French-Canadians, are very poor, live on small farms, and engage in fishing and hunting. The diet is mainly fish, potatoes and bread, with but little meat. The disease first appeared in 1820, among a family that came from Caraquet. At present there are only twenty-four patients in the Lazaretto, and the average length of residence is five years. A few cases are at large, and it is chiefly through the influence of the priests that they are detected and secluded. His conclusions are as follows:

1. Although it has been shown in other countries that the disease can be propagated purely by hereditary influences, no case has yet been recorded in Tracadie, so far as he could learn, which would prove that theory.

2. That the disease was imported from without, and, finding favorable surroundings, it spread from one to another by contagion. In order to contract the disease, certain conditions appear necessary: (a) low state of the system; (b) to belong to a certain race or family; (c) prolonged contact with leprosy persons.

SURGICAL SECTION.

Dr. Tye, of Chatham, Ont., in the chair.

Dr. Fenwick, of Montreal, read a paper on "Imperforate Anus with Fœcal Fistula." He first alluded to the various forms of this anomaly, and then described a case upon which he had operated successfully. There was a small opening at the site of the anus, and another in front of the scrotum at the root of the penis. The former was the result of an operation for imperforate anus, shortly after birth. He enlarged the opening, completely divided what appeared to be the continuation of the bowel forward to the scrotum, and stitched the bowel to the edges of the wound. The result was most satisfactory.

Drs. McLean, Holmes, Bethune, Campbell, and Walker took part in the discussion.

Dr. Worthington, of Clinton, Ont., then read a paper on "Retroversion and Retroflexion of the Uterus." He alluded to the general condition briefly, and then gave the notes of four interesting cases. In the third case, immediately on commencing a vaginal injection of hot water, the patient was seized with violent pelvic pain and symptoms of collapse, followed by a severe attack of peritonitis, and lasting for several days, but ending in recovery. The cases were treated by the Hodge-Smith pessary.

Dr. Gardner, of Montreal, alluded to the difficulty in treating such cases. In certain cases he thought it might be justifiable to adopt Lawson Tait's plan of suturing the fundus of the uterus to the abdominal wall. In regard to the collapse in one of the cases, he thought it was due to the contact of water, a foreign element, with the endometrium. The nozzle of the syringe should not have an opening at the end.

Dr. Holmes recommended a fountain syringe, the nozzle of which has no central aperture. He never uses the sound to replace the uterus, but places the patient in the knee-elbow position and makes pressure upon the fundus with two fingers in the vagina.

Dr. Fulton recommended mild medicated solutions in preference to plain water, for vaginal douches, as being less irritating. He also endorsed the plan of replacing the uterus by position and the fingers in the vagina or rectum.

Dr. Hingston, while agreeing in the main, deprecated such heroic measures as those alluded to by Dr. Gardner. He thought it was not justifiable unless in the most extreme cases.

Dr. Tye alluded to two cases where fatal results followed the use of vaginal injections.

Dr. Campbell, of Seaforth, next read a paper on "An Anomalous Case of Strangulated Femoral Hernia." The patient was not operated on for three and a half days after the onset of the symptoms because of certain peculiarities in the case.

Taxis was tried, but without success; but owing to the mildness of the symptoms, the operation was postponed, after due consultation and deliberation, for the time mentioned.

Dr. Roddick thought surgeons were too timid in regard to the amount of force to be used in taxis, and recommended much more than is usually applied.

Dr. Fenwick stated that Prof. Lister operates by cutting off the sac and suturing the edges of the incisions, with good results, by way of radical cure.

Dr. Saunders, of Kingston, thought Dr. Roddick's advice might lead to serious consequences in some cases.

Dr. McLean, of Ann Arbor, believed a new era was dawning in the treatment of hernia, and that operations for the radical cure would soon be more frequent than they were now.

Dr. Sullivan thought it unadvisable to wait in all cases for urgent symptoms.

Dr. Bethune instanced a case of radical cure of hernia after a kick on the truss which the person was wearing.

Dr. Sloan found it necessary, in some cases, to use considerable force in the taxis.

Dr. Hingston emphasized the importance of operating early. First use taxis under chloroform, and if it fail, operate at once.

Dr. McDonald, of Londonderry, N.S., read a paper on "Paracentesis Pericardii." He aspirated near the site of the apex of the heart, in the 5th intercostal space, and removed 32 ounces of slightly turbid serum. The patient made a good recovery. (This paper will appear in a future issue.)

Dr. James Bell, of Montreal, next read a paper on "Resection of Intestine." The paper consisted of the reports of fourteen cases of experimental resections of portions of the intestine of dogs. Of the 14 dogs operated upon, four died from preventable causes, one escaped on the fifth day after the operation, and nine recovered. From three to thirteen inches of different regions of the bowel were removed, including in one case the cæcum and portions of the gut on either side. The ends of the gut were united in some cases by catgut, and in others by silk sutures, and no attempt was made to remove the mucous membrane so as to bring the cut surfaces of the outer coat into accurate contact. The portions of bowel which had been thus united were exhibited and showed perfect union. The writer considered the operation an easy and a safe one, and predicted that in the near future it would be generally recognized as such, and many lives would be saved by it.

Dr. Bell was complimented by several speakers on the originality of his paper.

Dr. Sheard, of Toronto, exhibited a specimen of intussusception of the bowel, and said that, in his opinion, the patient might have been saved by an

operation of the kind performed by Dr. Bell in his experiments on the dogs.

The section then adjourned.

SECOND DAY.

The Association met at 10.30 a.m., the President in the chair. Minutes of the last meeting read and confirmed.

Dr. Fulton, of Toronto, read the report of the Committee on Necrology. A large number of members had died since the last meeting. Some of those who had passed away were comparatively young, others well advanced in years, but the majority of them were between the ages of 40 and 60 years. Two or three were painful instances of self-destruction by alcohol and drugs. The list contained 38 names.

Dr. Thorburn, of Toronto, presented the report on education. He referred to the establishment of schools for women in Toronto and Kingston. He also congratulated the profession of New Brunswick on the steps to advance medical education, by establishing a medical council and examining board.

MEDICAL SECTION.

Dr. Graham in the chair.

Dr. Tobin, of Halifax, N.S., read a paper on "Pigmentary Degeneration of the Retina." He gave a case of four deaf-mutes in one family, all of whom presented characteristic symmetrical changes in the eyes in the form of scattered pigment masses on the retinae, often in stellate forms. The parents were cousins, and he was inclined to believe that a considerable portion of cases occur as the result of consanguineous marriages.

Dr. Buller, of Montreal, had seen very many instances of the kind, and had never succeeded in tracing any connection between consanguinity and pigmentary degeneration; nor had he been more fortunate in trying to associate such cases with hereditary syphilis.

Dr. Fife Fowler, of Kingston, showed a child with enlargement of the smaller joints, wrists, ankles, and phalanges, due apparently to effusion. There had been enlargement of the spleen and the child had been ailing for many months.

Dr. Burnham, of Toronto, showed Dr. Mortimer Granville's percuteur, and explained its mechanism. He had brought it from London for a lady affected with persistent tic, which had resisted all modes of treatment, but had been greatly relieved by the use of the percuteur. About one hundred and fifty percussions were made in the second. Dr. Granville had found it very efficient in neuralgias and the lightning pains of tabes.

Dr. Osler read a paper on "Some Features in Chronic Bright's Disease." He referred to its latency at the outset, often simulating other diseases, to the peculiarities in the mode of onset of the uræmic

symptoms, and to the fact that patients frequently die with profound uræmic symptoms, highly albuminous urine, and numerous casts, yet, on *post mortem* examination, no coarse changes can be made out. He gave cases in illustration of each.

Dr. Graham spoke of the use of the sphygmograph in the detection of the disease. He referred to a case in which there was very little albumen, no diminution in the amount of urea, yet the patient died in five weeks.

SURGICAL SECTION.

Dr. Tye, of Chatham, in the chair.

Dr. Holmes, of Chatham, read an interesting paper on "Erosions of the Female Urethra." He had tried various plans of treatment, such as division of the urethra, stretching, etc., but found most benefit from injections of nitrate of silver. He asked for information regarding the etiology of such cases.

The paper was discussed by Drs. Fulton, Hingston and Sheard.

Dr. Hingston, of Montreal, showed to the Section a *note-book* which he had prepared for *ovarian and abdominal tumors*, and which he thought might be of some service.

Dr. Major, of Montreal, read a paper on "Naso-Pharyngeal Growths," and the modes of removal. Several interesting specimens were shown.

Dr. Oldright, of Toronto, read the notes of a case of "Fibro-Myxoma," and showed the specimen.

Dr. Proudfoot, of Montreal read an exhaustive paper on "Color Blindness," and exhibited Thomson's instrument.

The following papers were read by title: "Common Errors in Ophthalmic Practice," by Dr. Buller, Montreal; "Notes on Intra-Uterine Growths," by Dr. Gardner, Montreal; "Spindle-Celled Sarcoma," by Dr. Sheard, Toronto.

The afternoon and evening were spent in an excursion among the Thousand Islands.

PUBLIC HEALTH SECTION.

Dr. Sweetland, of Ottawa, was appointed chairman. Dr. Campbell, of Seaforth, secretary.

Mr. Boxer, C. E., of Montreal, was asked to address the Section and state what steps had been taken by way of organization.

On motion of Dr. Oldright, seconded by Dr. Robillard, of Ottawa, it was decided to organize a Canadian Sanitary Association, and Mr. Boxer presented a scheme for its establishment. The meeting then adjourned.

After assembling Dr. Playter read an address, and was followed by Mr. Boxer, who gave a report of the provisional conference held in Ottawa in December last.

Dr. McDonald, of Londonderry, N.S., moved the inauguration of the Society, seconded by Dr.

Oldright. The following officers were elected :— President, Dr. Sweetland, Ottawa. Secretary-Treasurer, F. N. Boxer, Montreal. Vice-Presidents, Ontario, Dr. Covernton, Toronto ; Quebec, Dr. Roy, Quebec ; New Brunswick, Dr. Botsford, St. John ; Nova Scotia, Dr. Macdonald, Londonderry ; Prince Edward Island, Dr. Conroy, Charlottetown ; Manitoba, Dr. Lynch, Winnipeg. Executive Committee for Ontario, Prof. Galbraith, Toronto ; Prof. Harris, Kingston ; Dr. McCammon, Kingston ; Dr. Oldright, Toronto. For Quebec, Dr. Larocque, Montreal ; Dr. Rinfret, Quebec ; Ald. Fairburn and Mr. Hughes, Montreal. For Nova Scotia, Hon. Dr. Parker, Halifax ; T. Slewens, C. E., Antigonish. For New Brunswick, Dr. Harding.

MILITARY SURGEONS.

A number of the militia surgeons present held a meeting to consider the position of medical men in the force. Dr. Fenwick, of Montreal, surgeon of the Montreal Garrison Artillery, occupied the chair, and Dr. Neilson, of "B" Battery, acted as Secretary. It was pointed out that medical officers had no status, no positive rank, their presence amongst the officers being by courtesy. Some recommended that in the Militia Department there should be officers holding rank equal to Deputy Adjutant-General. Instead of the colonel of the regiment appointing the medical officer it should lie with the Deputy Adjutant-General. There should also be medical officers attached to each military district in charge of the stores, with instructions to issue them to the regimental officers, these to be responsible to the Deputy Adjutant-General. Their rank ought to be the same as in the United States army. Touching camp equipments, they were considered very meagre and unfitted for the service. There were practically no appliances for a doctor to work with. The pay, it was felt, should be better. A committee, composed of Drs. Bristol, Napanee ; Thornburn, Toronto ; Neilson, Kingston ; Gardner, Montreal ; and Ruttan, Napanee, was appointed to prepare resolutions embodying the views which had been expressed, which were adopted and ordered to be sent to the Minister of Militia. The resolutions also urge the advisability of changing the titles and designations of Canadian medical officers so that they will correspond with those held by the medical officers of the British service, thus : Surgeon, instead of Assistant-Surgeon, Surgeon-Major instead of Surgeon, Brigade-Surgeon instead of Surgeon-Major, Deputy Surgeon-General, etc.

Interesting exhibits of elegant pharmaceutical preparations were made by Wyeth Bros., of Philadelphia ; Maltine Manufacturing Co., Reed & Carnrick, New York ; New York Pharmacal Association ; also of surgical instruments by Stevens & Son, and E. A. Smith & Co., Toronto.

THIRD DAY.

The Association met at 10.30 a.m., Dr. Mullin in the chair.

A number of papers were taken as read, and handed to the secretary.

Dr. Saunders, of Kingston, called the attention of the members to a remarkable case of tumor of bones of the skull in a child in one of the ante-rooms. The Nominating Committee reported the following list of officers for the ensuing year :

President—Dr. Sullivan, of Kingston, Ont. *Vice Presidents*—Ontario, Dr. Thorburn, of Toronto ; Quebec, Dr. Robillard, of Montreal ; New Brunswick, Dr. J. Christie, of St. John ; Nova Scotia, Dr. McDonald, of Londonderry ; Manitoba, Dr. Lynch, of Winnipeg. *General Secretary*—Dr. Osler, of Montreal. *Treasurer*—Dr. Sheard, of Toronto. *Local Secretaries*—Ontario, Dr. Bray, Chatham ; Quebec, Dr. Bell, Montreal ; New Brunswick, Dr. Coleman, St. John ; Nova Scotia, Dr. Black, jr., Halifax ; Manitoba, Dr. Betts, Winnipeg. *Auditors*—Drs. Walker, Dundas ; and Yeomans, Mount Forest. *Committee of Arrangements*—Drs. Hingston, F. W. Campbell, Ross, Roddick, Lachapelle, Gardner, and Rodger, with power to add to their number. *Publication Committee*—Drs. Ross, Cameron, Fulton, and Sheard ; *Medicine Committee*—Drs. Graham, Ross, Oliver. *Surgery Committee*—Drs. Roddick, Atherton, Tye ; *Obstetrics Committee*—Drs. Lavell, sr., Holmes, Lawson. *Therapeutics Committee*—Drs. G. Wright, Stewart, Small. *Necrology Committee*—Drs. Fulton, A. Wright, J. C. Cameron. *Education Committee*—Drs. C. Cameron, Bray, Yeomans, Bayard, Parker, Whiteford, Wilkins. *Public Health Committee*—Drs. Canniff, Oldright, Robillard, Yeomans, Harding, Larocque, Playter, Botsford, Worthington, Wickwire, Covernton, and Bryce. *Ethics Committee*—Drs. Mullin, Harrison, M. Cameron, Bray, Prevost, Grant, Osler, Almon, Coleman. Delegates to the American Medical Association—Dr. Grant, Ottawa ; Drs. Gardner, and Hingston, Montreal. Delegates to the American Public Health Association, to meet in Detroit in December—Drs. Larocque, Tye, Bray, Holmes, Sweetland, and Covernton.

Montreal was selected as the next place of meeting, the date being left to the President and Secretary, in order to place it a few days before the meeting of the British Science Association, which meets in Montreal on the 27th of August, 1884.

After votes of thanks to the President, railway and steamboat lines, etc., the Association adjourned.

A correspondent of the *British Medical Journal* states that he has found the application of a strong solution of chromic acid three or four times, by means of a camel's hair pencil, to be the most efficient and easy method of removing warts. They become black and soon fall off.

Selected Articles.

TREATMENT OF FRACTURES IN BRITISH HOSPITALS.

There is, perhaps, no other province in the wide domain of surgery, in which similar and equally satisfactory results are so commonly brought about by a variety of means than in the treatment of simple fractures of the limbs. And this is the case, not because any great diversity of opinion exists as to the end that is to be desired, for that cannot be alleged in this particular instance, but rather because the result sought for is in all cases identical, though capable of being accomplished by very many forms of treatment, which differ in their detail, and allow scope for the ingenuity, and dexterity of the individual surgeon.

Fractures of the limbs are so common, that it is not a matter of surprise that we find at each institution some recognized method, which is sanctioned by custom and hallowed by time, for meeting all the more common forms of each injury, whilst any complication that may be found needs generally but a very slight modification of the apparatus. And this is rendered all the more necessary seeing that such injuries, except when complicated by some serious addition, such as severe injury to a joint or rupture of an artery, are treated in the first instance by the house surgeon, and the surgeon on his visit is rarely called upon to do more than approve, or at most to suggest some slight alteration in the apparatus.

Except there be some other injury, or on account of the feebleness of the patient, or in event of some serious complication to a joint or artery, cases of fractures of the upper extremity are usually treated as out-patients, thus coming entirely under the care of the house surgeon and his dressers, and this renders it necessary that a convenient and portable apparatus shall be applied to keep the ends of the injured bone in good apposition. It would be impossible to enumerate the many ways in which fracture of the clavicle is dealt with, or the many ingenious appliances which have been invented by surgeons and instrument makers; but speaking only of hospital practice, the result obtained by a simple bandage with or without a pad in the axilla, and applied so as to throw back the shoulder upon the injured side, to raise and keep steady the humerus, and to take off the weight of the arm, are as satisfactory as could be wished for. Sometimes the figure-of-eight bandage, with a sling for the arm, produces the desired effect, whilst in other cases where it is difficult to overcome the deformity, the surgeon must rely upon his skill in using and applying a bandage, with a pad secured in the axilla by a strap passing over the opposite shoulder.

Fractures of the scapula do not commonly occur without either severe bruising of the surrounding parts or some other more serious complication, of which fractured rib is by far the most frequent. When they do occur without any serious complication, the treatment consists only of a sling or bandage to steady the arm and take off the weight of the limb, and this is all that can be done if the acromion or coracoid process be broken.

Before speaking of the mode of treating the long bones in detail, it may be well to mention some of the materials which are in use in London at the present time for securing the position of fractures, after the application of splints has been dispensed with, as these means are not uncommonly found available in the first instance, and can be applied in many instances where there is no bruising, and where only one of two bones is broken, as happens particularly in the case of a fracture of the fibula or radius. The principal of these are, the starch or glue bandage, the plaster-of-Paris bandage, and one made stiff with dextrine, gum, and chalk, etc. A very useful material for this purpose has long been in use at St. George's Hospital, and can be applied in the first instance in treating fracture of the fibula without bruising, and is almost invariably employed to put up fractures of the thigh or leg as soon as union has taken place and the splints can be laid aside. A piece of ordinary stout mill-board is cut to about the size necessary to embrace the limb; it is then soaked in hot water, which renders it pliant and is shaped roughly to the limb, the edges being torn carefully so as to form a bevelled margin. A piece of flannel is then placed round the limb, or a simple roller is applied, and then a bandage is neatly and firmly carried from the toes to a distance above the joints between which the fracture is situated, and closely embracing the mill-board. This, on drying, makes a very convenient apparatus, light and strong, and in order to increase its strength and to keep the bandage from becoming unravelled, a thick coating of clarified gum is pasted over the bandage. The starched bandage which is in use at University College is applied in much the same manner, coarse pasteboard soaked in starch being used, and the limb being surrounded by an even layer of cotton-wool before this is applied. This being elastic, avoids the danger of compression which might ensue when this treatment is followed, as it often is, in the case of recent fractures; and the apparatus has the advantage, when thus applied, that it can, if necessary, be split up by a strong pair of pliers, and its width curtailed, while its efficacy for support can be re-established by the application of tapes or a fresh bandage. With one of these forms of permanent apparatus it is almost invariably the custom to treat fractures after union has taken place, and in many instances where the displacement is not great and the extravasation slight, recent fractures are also treated in the same way.

In the case of the bones of the leg, a junk is sometimes slung in a "Salter's Swing" and the limb placed in it for a few days, until all swelling and bruising have disappeared. A solution of silicate of potash is sometimes preferred to either of the above-named materials.

To return, then, to the consideration of the fractures of the various bones and the usual plans for their treatment. In London hospitals the general method adopted in cases of fracture of the shaft of the humerus is to put the arm up in four well-padded wooden splints tied together by two pieces of bandage which are made to encircle them, one above and one below, and the forearm, being supported by a sling round the neck, gives sufficient extension to ensure a good position of the broken ends. The fingers and forearm may be left unbandaged, unless there is a tendency for these parts to become swollen, and this treatment is usually continued until union has taken place, but the plaster-of-Paris bandage can be applied as soon as all swelling has subsided. This form of treatment can be used in all cases of fracture of the shaft, except those of the condyles or of the lower end of the bone, for which a rectangular wooden splint is almost always resorted to, with or without three additional flat splints to encircle the humerus, the one arm of the right angle being placed along the front of the forearm, and the other along the anterior aspect of the humerus. Any immovable apparatus is disapproved of in this locality on account of the desirability of making early movement in the elbow joint, which generally is more or less injured when the accident takes place, and is therefore liable to become stiff if passive motion is not commenced at an early stage.

The old plan of treatment of fracture of the olecranon was to put a long straight splint on the anterior aspect of the arm and thus keeps it fully extended, whilst the fragments were brought as nearly as possible into apposition by a figure-of-eight bandage. But when, by the action of the triceps the upper portion of the ulna was drawn a long way up the arm, this plan was not found to give very good results, which answered, however, sufficiently well when the fibrous covering of the bone held sufficiently together to prevent any great separation of the parts. Accordingly, the plan which has been successfully carried out in the case of patella has been tried for the ulna, and the parts brought closely together by a silver wire passed through holes drilled obliquely down from the surface of each fragment. Under the antiseptic system this mode of proceeding has been attended with remarkable success in the few cases which have been reported, but it remains to be seen whether it is capable of being more generally followed.

A couple of well-padded, straight, and flat wooden splints are generally all that is required to keep the bones of the forearm in position when fracture

takes place in the shaft of one or both, but many plans are in use for correcting the deformity in the injury which goes by the name of "Colles's fracture." Some surgeons use these same splints, and by a turn of the bandage which keeps them in position, passed over the hand, maintain it at an angle downward to the side of the ulna, and obtain satisfactory results. Another very useful apparatus, by which the deformity is more easily corrected, is that invented by Dr. Gordon, of Belfast, who denies that impaction of the broken ends of the radius is of common occurrence, and corrects the deformity "by traction on the hand or pressure on the fragments, placing the hand in the prone position, then applying to the anterior surface of the forearm a splint to which a wooden conical or triangular piece is so attached that the external border of the splint projects beyond it; and on the back of the forearm a straight splint more thickly padded over the wrist than over the forearm," the whole to be fixed by two straps of webbing, and not by bandage. A more convenient and less complicated method in common use is a pistol-shaped splint applied to the back of the hand, with or without a short straight splint to the front of the forearm, and not extending beyond the wrist; the two being kept in position by a bandage.

Passing to the lower limbs, and to the fractures which occur in the femur, the plan of treatment usually followed in London hospitals is by one of the two forms of long splint reaching from the axilla down to the foot, and applied with or without shorter splints surrounding the thigh. When these are applied the foot is fixed by bandages to the lower end of the splint, and to an iron foot-piece which runs out at right angles to it, the form of splint known by the name of the French surgeon Desault, and this is secured to the body by a band passing round the waist, and runs up on the outer side of the body to the axilla, having a fork cut in its upper extremity for the purpose of giving a secure *point d'appui* for the perineal band, as it is called, by which traction is made. On this band are threaded three short flat splints, the upper ends of which are cut obliquely so as to fit the line of the groin, and these, with the long splint, surround the whole thigh, and are kept in position by one or more pieces of webbing. The whole having been properly adjusted, traction is made by tightening the perineal band, which, by passing over the upper end of the long splint round the groin and behind the nates, causes extension of the whole limb, and brings the fractured surfaces into close and accurate apposition. The shorter splints are, however, very frequently dispensed with, and then extension is affected by means of a weight applied with strapping to the leg and passing over the end of the bed, where an apparatus is fixed with a rest, over which the cord attaching the weight of seven to nine pounds is passed; and to further the effect of ex-

tension the lower end of the bed is slightly raised by blocks, so that the weight of the body may act in a manner to extend from the opposite direction. A patient thus treated is usually kept in bed for from four to seven weeks, and then one of the forms of immovable apparatus is generally applied, plaster-of-Paris being less frequently used in the case of the thigh on account of the great weight which a splint made with this material necessarily involves. With very young children the best results are often obtained by using a weight to the leg as above described, while to secure the limb from movements during sleep, and to keep the fragments in good position, a sand-bag is placed on either side of the thigh, and to another laid across the seat of the fracture; and further to prevent the patient from slipping down, and so nullifying the influence of the weight, a band is passed behind the back, from which two loops pass over the shoulders, and this is tied beneath the bed or secured to its upper end. One of these forms of treatment suffices in almost all fractures of the thigh bone, but there are some in which the broken ends cannot be kept in position by any such means, and this happens particularly when the break occurs a short way below the trochanters, and the upper fragment is drawn upward and inward by the action of the psoas. For these cases the most frequent apparatus used is Earle's bedstead, which allows the patient to lie flat on his back, but the foot being secured on the injured side to a footpiece, the knees are bent over the raised portion of the bed, which thus forms a double inclined plane, the traction is kept up by the weight of the body, the knee thus becoming practically a fixed point. Many other ingenious modes of effecting the same results have been invented and are occasionally used, but they are not in general use, and are only required in exceptional cases; such, for instance, are the methods of placing the limb in a wire support, without splints, and making extension by a weight attached to the foot and passing over a pulley, which is placed at some height and distance from the end of the bed, or the splint known by the name of "Thomas," which consists mainly of a couple of parallel iron rods united at both ends, the upper being secured round the pelvis and the lower to the foot, whilst a bandage passes round the whole apparatus and gives support to the lower part of the limb.

The treatment of fracture of the patella varies in detail at almost every institution, but the main points are to reduce the effusion into the synovial membrane of the knee joint, by which the primary separation of the fragments is mainly produced and maintained, and then to bring the two surfaces as nearly as possible in apposition. The first object is attained by raising the limb to an angle with the trunk on pillows, junks, or other apparatus, and applying evaporating lotions to the joint, and the second, by the use of bandages applied in various

fashions, strapping, to which is sometimes attached a weight, which passing over the foot is intended to drag down the upper fragment and to act counter to the retraction of the quadriceps extensor. Some surgeons still use Malgaigne's hooks, but they are objectionable on account of the risk of inducing erysipelas. The operation of wiring together the fragments has already been alluded to, and has now been performed in a considerable number of instances, but the danger, even with the utmost aseptic precautions, is sufficient to deter surgeons from recommending the operation, especially when the accident occurs, as it most frequently does, in persons past the healthiest period of life, and also considering the very useful limb which is obtained by patients who are willing to submit to a prolonged course of treatment by simple means. Where the separation of fragments has taken place after fibrous union between the two ends of bone, the operation has been resorted to in several cases with more or less satisfactory results. Where splints are used for the treatment of fractures of the bones of the leg, those which bear the name of Cline are, perhaps, most frequently had recourse to. They consist of two pieces of light pine wood, roughly hollowed out and shaped to embrace the outer and inner surfaces of the calf, ankle and foot, a round hole being cut for the malleolus in each. These are padded with tow or cotton-wool, and are fixed to the foot by pads and bandages, whilst they are secured round the leg by two pieces of broad webbing. Other surgeons prefer to support the back of the limb, and for this purpose use three flat deal splints to which a foot-piece is applied, and these are kept in position by webbing and strapping or bandages. Whatever form of splint is used, the custom is almost invariable of swinging or raising the limb, either by junks or by the use of "Salter's swing," which allows the patient to exercise more movement of the body without disturbing the injured extremity. In some cases where the swelling is not great, the limb is placed in plaster-of-Paris, by laying strips of blanket soaked in the plaster on either side of the leg, and bandaging with muslin into which the dry plaster has been rubbed, cotton-wool being used, or, as some prefer, a flannel bandage, to guard against the risk of subsequent swelling. For Pott's fracture, where ecchymosis forbids its immediate treatment by some immovable apparatus, the practice recommended by the Dublin surgeon is usually adopted, namely, to place a single flat wooded splint upon the inner side, with a thick pad over the inner malleolus, and to secure to this the foot below and the leg above by a light bandage.

The same apparatus suffices in the treatment of compound as in simple fractures, the more so as the wound is almost invariably treated on antiseptic principles, more or less strictly carried out in the manner of Professor Lister. Some surgeons, however, still adhere to the use of "Assalini's fracture-

box," a weighty and somewhat cumbrous machine, whilst others prefer MacIntyre's splint, which has the advantage of being more easily cleaned, and is thus less likely to become a medium of conveying or retaining the germs of contagious diseases.—*W. Lancet*.

ON THE USE OF ANÆSTHETICS DURING LABOUR.

—In a paper recently read before the East Surrey District of the South-Eastern Branch of the British Medical Association, Dr. Savill indicates what he believes to be the main precautions, the observations of which would render the use of chloroform perfectly justifiable. 1.—There are certain women who have a tendency to flood at every confinement, and others in whom there seems an already too great relaxation of fibre—weak anæmic females in their eight or tenth confinement; and to these it would be inadvisable to give chloroform, except for necessity. Happily, it is not these women who suffer the most pain, but rather those strong healthy primiparæ whose pelves and general build approximate to the masculine type. 2.—We should not give it when labour is complicated with severe vomiting, or with acute heart or lung-disease, unless there be imperative call for it. 3.—It should not be given to the full extent, except for operation, convulsions, or spasm of the cervix; and then it is most necessary that one person should devote his entire attention to it. 4.—The inhalation should be stopped directly we find the pulse becoming very weak, or respiration irregular. 5.—Anything which makes us suspect a fatty or enfeebled cardiac wall should make us cautious in the use of chloroform. Here, as in cases other than those of labour, it is not the most extensive valvular disease (so long as it be attended by compensating hypertrophy), but the atrophied or degenerate wall that constitutes the source of danger. Unfortunately, the signs of these conditions are subtle and uncertain. Fatty heart may be suspected by an exceedingly feeble cardiac impulse, combined with an almost inaudible first sound; or valvular lesion; or copious deposit of fat in other parts of the body, and the occurrence of dropsy without adequate cause. A dilated heart may be suspected by increased area of præcordial dulness, combined with epigastric and venous pulsation, and a want of correspondence between the violence of the cardiac impulse and the strength of the pulse. Pericardial adhesions also form a great source of danger. They may be suspected when the heart's apex is fixed above its normal position, and does not shift with respiration; or when there is depression instead of protusion of intercostal spaces over the position or the apex, giving a wavy character to the cardiac impulse. 6.—In all cases, we should take extra care to prevent the occurrence of hemorrhage after birth; by giving a full dose of ergot when the head reaches the perinæum; by

ceasing the chloroform immediately it is born; and by rousing the patient from the lethargy as soon as possible.—*British Medical Journal*.

MANGANESE IN THE TREATMENT OF AMENORRHŒA.—Dr. S. Ringer and Dr. W. Murrell (*"Lancet,"* Jan. 6, 1883) have been using permanganate of potash extensively, in hospital practice, for amenorrhœa, with good results. They have used it both in the pharmacopœal (B. P.) solution and in the form of one or two-grain pills. One grain three times a day is given to begin with, and this is increased to two grains four times a day, the larger doses giving the best results. Its administration should be begun three or four days before the period is due, and if it is not successful in bringing on the flow, its use should be continued for some time, even until the next period is due, if necessary. It should be discontinued as soon as the flow appears, as its use will facilitate that process. Its action is not so certain in the case of girls who have never menstruated, though, after having been tried unsuccessfully, it may be successful if tried at a subsequent period. It is also recommended in the case of women who have reached middle life, having passed through numerous pregnancies, and have become irregular. It is necessary to avoid giving it during pregnancy for any cause, though it is not known that it will produce abortion. In the amenorrhœa of phthisis it is not thought to be of value. The pills will usually be found to be more acceptable to the patient, as to any disagreeable after-effect, than the solution. Manganate of sodium and binocide of manganese are equally effective with the permanganate of potash. Manganese does not seem to improve the condition of the blood in anæmia and chlorosis, but acts equally well with the plethoric and the anæmic.—*N. Y. Med. Jour.*

WHO WOULD NOT BE A DOCTOR?—Quite a number of our young men are studying for the medical profession. We do not wish to deter them from this laudable pursuit, for a physician's calling is one of the most honorable, ennobling, humanizing, and useful in the world. But all is not gold that glitters, and the following are some of the sweets of a doctor's life: If he does not write a prescription for every trifling ailment, he is careless; if he does, "he deluges one with medicine." If his horse is fat, it is because he has nothing to do; if he is lean, it is because it isn't taken care of. If he drives fast, it is to make people believe somebody is very sick; if he drives slowly, he has no interest in the welfare of his patients. If the patient recovers, it is owing to the good nursing he received; if he dies, "the doctor did not understand his sickness." If he talks much, "we don't like a doctor to tell everything he knows," or, "he is altogether too familiar"; if he don't talk, "we

like to see a doctor sociable." If he says anything about politics, "he had better let it alone"; if he don't say anything about it, "we like to see a man show his colors." If he does not come immediately when sent for, "he takes things too easy"; if he sends in his bill, "he is in a terrible hurry for his money." If he visits his patients every day, it is to run up a bill; if he don't, it is unjustifiable negligence. If he orders the same medicine, it does no good; if he changes the prescription, he is in league with the druggist. If he uses any of the popular remedies of the day, it is to cater to the whims and prejudices of the people, to fill his pockets; if he does not use them, it is from professional selfishness. If he is in the habit of having frequent consultations, it is because he knows nothing; if he objects to having them, on the ground that he understands his own business, "he is afraid of exposing his ignorance to his superiors." If he gets pay for one-half his services he deserves to be canonized. Who wouldn't be an M.D.?

TO STOP HICCOUGH.—Dr. Martin Burke, of New York city, sends the following item to the *New York Medical Review*: "Perhaps the narrative of these two cases may prove of interest. John C.—was suddenly seized about a year ago with an attack of hiccough. The cause was unknown. All the usual remedies were tried in vain. Dr. John Burke, my father, was then called upon. Noticing the convulsive heaving of the patient's ribs, more particularly upon the left side, he firmly compressed the side between his two hands, and in a short time the hiccough ceased for the first time in days. The second case was that of a Mr. C—, a young man of thirty. He also was attacked, first with vomiting and then with hiccough, most violent and convulsive. Morphine suppositories would produce sleep, but even in sleep the hiccough was distressingly severe. As his vomiting had now ceased, almost every remedy known was called to our aid, but it was not until we had again, by my father's advice, compressed his heaving ribs, that the hiccough almost instantly ceased. It returned indeed within twenty-four hours, but compression again arrested it. The patient is now convalescing, and as hiccough very often proves fatal, perhaps the record of these two cases may prove of service."

THE KEY-RING ARTERY-CLAMP.—In the *London Medical Record* for July, '83, Dr. Brewer Mattocks, of Faribault, Minn., describes the following useful contrivance: "In a country of long distances, one must betake himself to many short contrivances. A professional neighbour of mine, his assistants failing him, performed lately his first ovariectomy successfully alone. With us, every farm has from two to an indefinite number of horse-power agri-

cultural implements, and every town its railway and manufactories; consequently we see much of *accidental* surgery. Of necessity, then, our surgical instruments must to a great extent be both automatic and labor-saving. The artery-clamp, of which I send an illustration, explains itself; but



the advantages claimed for it I will number consecutively. 1. The operator is by the use of the clamp enabled to tie the arteries himself and at his leisure. 2. It is self-holding, and its lightness will prevent its tearing loose, while its shape enables the ligature to slip to its place. 3. It is small, compact, and, if necessary, may be left in position for several days; for instance, after one has searched for an artery at the bottom of a wound. 4. It is especially adapted for cases of emergency, and, as its name suggests, several of them may form a part of one's key-ring furniture. 5. Its simplicity enables one to use it without a commentary, and its cheapness to buy a set of them." I am indebted to Messrs. Tiemann & Co., of New York, for perfecting my suggestions.

HYDRATED OXIDE OF IRON.—Dr. Squibb recommends the following as a simple method of preparing hydrated oxide of iron, the antidote for arsenic, one of its chief advantages being that the ingredients are always easily obtained. Take of

R—Tinct. ferri chloridi,	℥iv.
Aquæ font.,	℥iv.
Mix in a vessel of	℥xij capacity,
And add aqua ammon.	℥ij.

Shake well, pour it on a large wet muslin drainer, wring out the water and alcohol and wash with fresh water. The stomach having been evacuated by emetics while the antidote was being prepared, give ℥iv. at once, to be followed by an emetic. Then give ℥ij. every ten minutes.

PROPER METHOD OF TREPHINING.—In trephining for depressed fractures of the skull, always select the *smallest* trephine, since the only object of its use is to make such an opening as will permit the introduction of an elevator. If you desire to elevate and remove comminuted pieces, apply the crown of the trephine upon uninjured bone adjoining and overlapping the *least* depressed portion of the depressed fragments. It is much easier to remove the fragments when the opening is thus made, than when the trephine is applied at the side of the *most* depressed portion of the fracture. —*Polyclinic.*

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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DIPHTHERIA.

Although medicine as a whole may now be regarded as an exact science, yet very much remains that is speculative and inexact. Diagnosis and pathology have reached a marvellous degree of perfection. So have physiology and chemistry, although these latter are still fruitful in new discoveries and fresh surprises, and are marching forward at a pace unknown in any other department of science. Considering the difficulties in the way, the wonder is, not how little, but how much we know about the nature and treatment of disease. We must not however on this account shut our eyes to the fact that much yet remains to be learned, and that gross darkness prevails in many places where light would be no less a boon to humanity than a joy to the physician. One of the many dark spaces needing lighting up is the space covered by diphtheria.

As cold weather approaches diphtheria may be expected to break out with greater or less severity in many localities, and it is appalling to contemplate our therapeutic armor when brought to face with this terrible scourge. Every intelligent practitioner of experience must confess that all the vaunted remedies fail to meet the necessities of the worst cases. If this be not true, why this fearful slaughter of the innocents from year to year? In this disease, perhaps more than in any other, the profession has been in search of a specific, and there is reason to believe that life has been sacrificed at the shrine of this one dominant idea. Treatment,

based on general principles, is much safer than that based on doubtful theory, and in the long run will give better results. That physician who thinks least of specifics and antiseptics, and most of how best to sustain the vital forces, is to be commended, and is certain of his reward. Much of the belief in specific treatment takes its origin in false diagnosis. Of all the reported cases of diphtheria, not a fourth, perhaps, is diphtheria at all. Ulcerative tonsillitis and pharyngitis have materially enhanced the value of certain remedies, and have greatly swelled the number of reported recoveries. For these affections nothing could be more suitable than the routine treatment commonly followed in diphtheria. The patients, of course, all recover, and until the, as yet inexperienced practitioner, meets the genuine disease a few times, he considers his remedies infallible. A medical man was called upon to treat diphtheria occurring in a certain family. Two members of the family residing a few miles from home were taken down, one after the other, with a severe type of the disease. After a protracted illness both recovered. They were nursed by the mother. After a time the disease broke out in the family home, presumably from the infection being carried there by the mother. The first taken down was a lad ten years of age. The same physician was called in, but the patient died on the third day. The father and a grown-up son were attacked almost simultaneously with the fatal disease, but they soon recovered. The next attacked was a child, eighteen months old. At this stage a neighboring physician was called in. This gentleman objected to much of the treatment in force, and declared that he "never failed to cure the disease with Tr. ferri mur. and pot. chlor., internally, and turpentine externally." Everything else he regarded as superfluous. In their perplexity and deep distress, the family took the gentleman at his own estimate of himself, and so expressed themselves to the medical man in attendance, who at once withdrew. Within a few days following, three more of the family died, notwithstanding the attendance of a third physician. At this stage the presumptuous and confident man who had supplanted another and better physician, very properly received his discharge, and the original attendant was recalled to attend the last critical case and close up the sad history. The gentleman who invariably cured with iron and

potash had probably never before treated diphtheria, and there is good reason for believing that the fatality which followed, at least in part, was due to his neglect of other and more important points lying within the range of general and systematic treatment.

The local lesion is a fruitful source of error in treatment. It too often happens that this is regarded as the disease itself, open and exposed to view, rather than the manifestation of a grave constitutional malady. If this be not so, what means the torture of frightened and struggling infants with tongue-depressors, swabs and brushes? Almost every writer on the subject directs us to pencil or brush the throat with various substances, not with a view of disinfecting merely, but also to aid in the "removal of the false membrane," and otherwise exercise a beneficial influence. In view of the fact that the disease is constitutional, general treatment cannot be subordinated to local treatment, not even if the benefits claimed for the latter were true, which they are not. The removal of the "membrane," if accomplished before the disease had spent itself, would most certainly be followed by a new formation. But pathologists now tell us that the so-called membrane is not a membrane at all; that what appears to be such is nothing more nor less than tissue, which has been congested, presumably by micrococci, swollen by inflammatory products, and dead from being cut off from all nutrition. This discovery is very disconcerting to those who have laid undue stress on local treatment.

If we have much yet to learn about this disease—as indeed we have about all zymotic diseases, yet we know pretty well what it does. We know that it gives rise to certain grave constitutional disturbances, and chief amongst these, a tendency to weakened heart action. We know also that it gives rise to local lesions, marked by a tendency to necrosis of tissue. How best to meet these indications, may form the basis of some future remarks.

CANADA MEDICAL ASSOCIATION.

The meeting of the Canada Medical Association this year in Kingston, under the presidency of Dr. Mullin, was, upon the whole, a most interesting and successful one. The number in attendance,

though not so large as on many occasions of the kind, was considerably above the average of former years. With one exception, namely, the hotel accommodation, Kingston was a most desirable place for the meeting of the Association. The new buildings of Queen's College were admirably adapted for the meetings of the various sections, and the local committee spared no pains to make the visit of the members agreeable. The excursion among the Thousand Islands was the social event of the meeting and was highly appreciated. Indeed nothing was left undone by the Committee of Arrangements to render the meeting pleasant and agreeable, and one long to be remembered.

In the sections on medicine and surgery many interesting and valuable papers were read and discussed, and much good work accomplished. We were pleased to note an improvement in the character of the papers generally, and special mention should be made of two or three papers which were almost wholly the result of original work, in medicine and surgery. We hope at future meetings to see an increase in the number of papers of this character. The papers alluded to were much appreciated by the Association, and this of itself should be a stimulus to others to follow in the same direction.

It might not be out of place here to give a brief sketch of the history of the Association. It was organized in Oct., 1867. Dr. Marsden, of Quebec, one of the governors of the College of Physicians and Surgeons, of Quebec, took an active interest in its formation. In May, 1867, he introduced a resolution recommending that action be taken by the college of which he was a governor toward the formation of a Canadian Medical Association which should consist of all members of the profession in the Dominion in good standing. No action was taken, however, by the college, but the Quebec Medical Society held a meeting, appointed a committee to draft resolutions regarding the formation of an association, which were adopted, and circulars were issued to the medical men in Canada calling a meeting in Quebec on the 9th of Oct. 1867, when the association was inaugurated. There was a large number present and the meeting was most enthusiastic one. Hon. Dr. Tupper was elected first president and delivered a most interesting and eloquent address. He continued president until 1870, when he was succeeded by Hon.

Dr. Parker, of Halifax, N. S. The subsequent presidents were Drs. James A. Sewell, Quebec; J. A. Grant, Ottawa; W. Marsden, Quebec; LeBaron Botsford, St. John, N. B.; E. M. Hodder, Toronto; W. H. Hingston, Montreal; Joseph Workman, Toronto; R. P. Howard, Montreal; Canniff, Toronto; Fenwick, Montreal; Mullin, Hamilton, and Sullivan, Kingston.

The association meets next year in Montreal, a few days before the meeting of the British Association for the Advancement of Science, so that members may have an opportunity of remaining over to take part in that gathering, at which will be present many of the leading men and scientific lights of England. It is confidently expected that this meeting of the association in 1884 will be one of the most interesting and important in the history of the association. A pressing invitation was received from our brethren in the far West to hold the next meeting in Winnipeg, but for the reasons above mentioned Montreal was chosen. The President and Secretary will arrange the date of the meeting, which will have timely announcement through the columns of the LANCET and other journals.

THE NATURE AND TREATMENT OF DIPHTHERIA.—The following is a brief summary of the conclusions from replies to a series of questions recently issued on the subject by the *Therapeutic Gazette*:

1. Diphtheria may be either local or constitutional in its origin.

2. It may continue as a purely local or as a purely constitutional disease, or the local disease may be followed by constitutional infection, or *vice versa*—the disease in the vast majority of instances manifesting itself in both the constitutional disturbance and the local affection.

3. The comparative value of local and constitutional remedies is dependent upon the nature of the affection in individual cases.

4. Diphtheria is a contagious disease, but not liable to attack a healthy mucous membrane or to find an entrance through it into the circulation.

5. The contagium of diphtheria is not a micrococcus, nor is it visible under the most powerful microscope yet manufactured.

6. The contagium of diphtheria is of a gaseous nature (the result of decomposing *fæcal* and other organic matter), and can be neutralized only by a true disinfectant and not by an antiseptic.

7. The best local application is the tincture of the chloride of iron. It may be supplemented by other applications according to the indications in individual cases.

8. In a typical case of sthenic diphtheria, administer large (10 grains) and frequently repeated (hourly) doses of calomel until the characteristic stools are secured. Following this give large doses of the tincture of the chloride of iron every two hours, and administer alcohol within the limits of intoxication. In asthenic cases the calomel should be omitted, and the main reliance placed on the iron and alcohol.

THE GILCHRIST SCHOLARSHIP.—We are pleased to announce that Mr. H. G. Creelman, B.A., of Dalhousie College, N. S., has won the Gilchrist Scholarship. Mr. Creelman is, we understand, a near relative of Dr. Creelman, of Maitland, N. S., and nephew of the Hon. Samuel Creelman. The scholarship is of the value of £100 a year for three years, the condition being that the winner must pursue his studies either at the University of Edinburgh, or University College, London, prior to proceeding to the degree at the University of London. Mr. Creelman has chosen University College, and intends to make a special study of physics. This is the third time this scholarship has been won by a Nova Scotian, and a graduate of Dalhousie College.

PERSONAL.—Dr. James Stewart has returned from Vienna, and has taken up his residence in Montreal. He will deliver his first course of lectures on materia medica in McGill Medical School this winter.—Sir Wm. McCormack, surgeon to St. Thomas Hospital, London, and Prof. A. P. Simpson, of Glasgow University, are at present making a tour of the United States and Canada.—Dr. D. McLeod (Trinity), formerly adjunct Professor of Institutes of Medicine, Materia Medica and Therapeutics in the Michigan College of Medicine, delivered the spring course of lectures so acceptably that the trustees of that institution have promoted him to the vacancy caused by the withdrawal from the school of Dr. J. J. Mulheron.

SUBSCRIBE TO MEDICAL JOURNALS—Dr. Cathell says in his work "The Physician Himself," subscribe to as many medical journals as you can read, and can afford to pay for. Read them care-

fully so as to keep abreast of the times, but neither swear at, nor by all you see in them; be especially careful of such as exist for the purpose of advertising either their owner or his goods. Note all remarkable cases, but never report any that are not unique or at least that do not present some curious or unusual feature, or militate against accepted theories, otherwise you will merely swell without adding anything valuable to existing records.

BRITISH DIPLOMAS.—Dr. J. P. Brown, of Galt, double gold medalist Toronto University (1868) has recently passed the examination for the L.R.C. P. Edin. Dr. Brown spent the past summer in the Royal Infirmary, Edin., and the London and Samaritan Hospitals, London. Dr. G. S. Beck (Toronto), Drs. W. H. McDonald, and W. Nattress (Trin. College) have been admitted to the M.R.C.S., Eng. Dr. S. A. Metherell has taken the L.R.C.P. Edin. and L.F.P. & S. Glasgow. F. G. Finley, M.D., (McGill), has passed the intermediate examination for M.B. in the University of London, and D. G. Bennet of New Brunswick has taken the degree of M.B., C.M. in the University of Edinburgh.

Drs. J. Johnston, A. Hawke and J. H. McCullough (Trinity), have taken the L.R.C.P. Edin. Dr. J. C. Urquhart (Trinity), has taken the double qualification L.R.C.P. & S. Edin.

CORRECTIONS.—In our notice of Dr. D. Tod Gilliam's work on pathology, we inadvertently stated he was a professor in the Columbus Medical College. It should have been the Starling Medical College, Ohio.

The summary of the article on iron-dyed silk ligatures, by Prof. Pancoast, of Philadelphia, in our last issue, was accidentally omitted by the printer, together with the name of the journal, *Medical Bulletin*, from which the article was taken.

THE BRITISH MEDICAL BILL.—Although it was confidently expected that the Bill would be passed during the recent session of the British Parliament, it has been shelved for another year. Opposition was offered by the Irish and Scotch authorities interested at the last moment, and in consequence the Bill was withdrawn for the present. It is a good measure and will no doubt ultimately become law. A year's delay will only strengthen the hands of its friends and weaken the opposition of its enemies.

EUCALYPTUS GLOBULUS IN DIPHTHERIA.—A writer in the London *Lancet*, Sept. 1, '83, gives a list of 37 cases of diphtheria successfully treated by the use of steam saturated with eucalyptus globulus. He claims that the remedy contains properties which are antagonistic to the germs of diphtheria. He directs boiling water to be poured on the dry leaves and the steam to be inhaled constantly.

ACUTE RHEUMATISM.—The following will be found a most elegant mode of administering salicylic acid in the treatment of the above-named disease:

R Sodæ salicyl..... $\overline{3}$ ss.
Syr. limonis..... $\overline{3}$ j.
Aquæ cinnan..... $\overline{3}$ viiij.—M.

Sig.—A tablespoonful every four hours.

SANITARY ARRANGEMENTS ON ATLANTIC STEAMERS.—The British Medical Association are moving for a Parliamentary Committee to enquire into the inadequate medical and sanitary arrangements on the Atlantic steamers. Mr. Chamberlain, President of the Board of Trade, intends introducing into Parliament a bill dealing with the subject next year.

APPOINTMENTS.—Dr. M. A. B. Smith has been appointed House Surgeon to the Provincial and City Hospital, Halifax, N. S.

Dr. Sutherland, of Calgary, N. W. T., has been appointed physician to the Canada Pacific Railway, western section.

REMOVALS.—Dr. Stalker of Ripley has removed to Walkerton, Ont. Dr. Hurlburt, of Brucefield, has removed to Mitchell, Ont. Dr. J. S. Smiley, of Rawdon, Que., has removed to Portsmouth, Iowa.

The *Canadian Pharmaceutical Journal* for September, 1883, comes to us in an enlarged and very much improved form. We congratulate our city contemporary upon its improved appearance.

SCHOLARSHIP FOR WOMEN.—Mrs. Alex. Cameron of this city, has presented a scholarship of \$60 per annum to the Women's Medical College, Toronto.

Dr. Oliver, surgeon (retired) Army Med. Dept., has commenced practice in this city.

Reports of Societies.

BRANT COUNTY MEDICAL ASSOCIATION.

The above Society convened in Brantford on the 4th ult., Dr. Harris in the chair. After routine the Society proceeded with the election of officers for the ensuing year with the following result :

Dr. Wm. T. Harris, President ; Dr. Robert H. Dee, Vice-President ; Dr. Wm. E. Winskel, Secretary-Treasurer.

Dr. Griffin showed a specimen of cancer of the bowel at the ileo-cæcal valve, and gave a very interesting history of the case. Drs. Winskel, Dee, and Harris each furnished notes of cases from practice.

Dr. Fairchild, of Burford, was elected a member of the Association. After some further business, the society adjourned to meet in Brantford on the 4th of December.

Books and Pamphlets.

THE PHYSICIAN HIMSELF, AND WHAT HE SHOULD ADD TO HIS SCIENTIFIC ACQUIREMENTS. By D. W. Cathell, M.D., Baltimore, Md. Baltimore: Cushings & Bailey. Toronto: Willing & Williamson. \$1.25.

This unpretentious little book has already, within a very short time, passed through three editions. The aim of the work is to inculcate professional tact and business sagacity, which, the author states, are "as necessary to the physician as the mariner's compass is to the navigator." It contains much good sound sense, and in a business-like manner informs the medical practitioner what he must add to his professional attainments to make his success in life more certain, rapid and complete. We are very much pleased with a perusal of the book, and would cordially recommend it to our readers, and especially to the younger members of the profession.

MEDICAL ESSAYS. By Oliver Wendell Holmes. Houghton, Mifflin & Co., Boston, Mass., 1883.

This volume contains a series of papers on various subjects which have been previously published separately, at various times, between 1842 and 1882. In the form in which they now appear they will be read with interest by all who like well-

written essays by an author whose fame as the "autocrat of the breakfast table" is simply world-wide. His Essay on Homœopathy—and, indeed, every one of the nine subjects treated of in the volume, is well worthy of perusal as the work of a gifted and most pleasing writer.

A PRACTICAL TREATISE ON IMPOTENCE, STERILITY, AND ALLIED DISORDERS OF THE MALE SEXUAL ORGANS. By Samuel W. Gross, M.D., Prof. Surgery, etc., Jefferson Med. College, etc., etc. Second edition, thoroughly revised, with sixteen illustrations. Philadelphia: Henry C. Lea's Son & Co. Toronto: Willing & Williamson. 1883. Pp. 176.

A work of this kind is most desirable, as in all parts of the continent the disorders referred to abound, sometimes through the vicious practices of patients, often through the mischievous influence of the quack advertisements which pollute the columns of the newspapers. The author has greatly improved on the former edition in the present issue. The work is one that can be cordially recommended.

HOW TO DRAW A SIMPLE WILL; WITH SPECIAL INFORMATION FOR CLERGYMEN AND DOCTORS, AND INSTRUCTIONS FOR EXECUTORS IN ORDINARY CASES. By D. A. O'Sullivan, M.A., LL.B., author of Practical Conveyancing, including Wills; Government in Canada; etc. Toronto: Moore & Co.

The above-mentioned brochure by Dr. Sullivan will be found exceedingly useful to all classes of the community. Every person should know something about wills and the proper method of drawing them. It is the design of this work to supply just such information as is required in this respect, and the author is to be complimented on the skill with which he has accomplished the object in view. We cordially commend the work to our readers.

ELECTRICITY IN MEDICINE AND SURGERY. By Geo. C. Pitzer, M.D., St. Louis. Second edition.

The present edition of this work has been revised throughout and considerably enlarged by the addition of chapters on the use of electricity in diagnosis, its use in asphyxia, chloroform poisoning, opium poisoning, cauterization, and the like. It contains full directions for using batteries, the object being to furnish the beginner with the principal facts embraced in the subjects of electricity and

electro-therapeutics. It is very concise, and will no doubt be found useful by those who have yet to learn the first principles of electro-therapeutics.

THE PHARMACOPŒIA OF THE UNITED STATES OF AMERICA. Sixth Decennial revision. New York: Wm. Wood & Co. Toronto: Willing & Williamson.

The present edition is very much improved in many respects, not the least of which is the bold clear type in which it is printed. The committee of revision have done their work well. The defects, which are not numerous nor important, may be accounted for from the difficulty of the task before them. The revision of nomenclature will commend itself to all students of pharmacy. The titles of compound medicines are made to express their constituents, rather than their properties. There are a few exceptions, as for example, *Pil Cath. Co. &c.*, &c. The Latin names of alkaloids have been made to terminate in *-ina*, and the corresponding English names in *-ine* in preference to *-in*. A number of special alterations have been made after due consideration, as for instance: *alumen* for sulphate of aluminium, *chirata* for chiretta, *asafetida* for assafoetida, *cambogia* for gambogia, etc., etc.

THE PRINCIPLES AND PRACTICE OF SURGERY, by D. Hayes Agnew, M.D., L.L.D., Prof. of Surgery University of Pennsylvania. Profusely illustrated. Vol. III. Philadelphia: J. B. Lippincott & Co. Toronto: Willing & Williamson.

This is the concluding volume of this excellent work on Surgery. The present volume fully bears out the high character of those that preceded it, and which have been previously noticed in these columns. The learned and accomplished author is to be congratulated upon the production of a work on Surgery which has not been surpassed on this continent. As a work of reference it is of inestimable value to every practical surgeon. We cannot too highly commend the work to our professional brethren.

EARLY AID IN INJURIES AND ACCIDENTS, by Dr. Friedrich Esmarch, Prof. of Surgery, University of Kiel. Translated from the German by H. R. H. Princess Christian. Philadelphia: H. C. Lea's, Son & Co.

This work consists of a series of five popular lectures delivered in the so-called "Samaritan School," on this subject. The instruction in these lectures will be found of great value to the public, and the work should meet with a ready sale.

AN INDEX OF THE PRACTICE OF MEDICINE, by Wesley M. Carpenter, M.D., Pathologist to Bellevue Hospital. New York: Wm. Wood & Co. Toronto: Willing & Williamson.

This work is gotten up very elegantly, in wallet form, and adapted for carrying in the pocket. The information is given in a concise form, namely, symptoms, diagnosis and treatment, and the pages are interleaved to facilitate note-taking in important cases. The work will undoubtedly serve a useful purpose in general practice.

GOUT IN ITS PROTEAN ASPECTS. By J. A. Milner Fothergill, M.D., M.R.C.P., London. Detroit: George S. Davis, 1883.

This is an eminently practical book, like all Dr. Fothergill's works; and any one who wishes, in small compass, to make himself familiar with the latest views regarding gout in all its forms, cannot do better than read its thirteen well-written chapters carefully.

WHAT TO DO FIRST IN ACCIDENTS AND EMERGENCIES, by Chas. H. Dulles, M.D., second edition. Revised and enlarged, with new illustrations. Philadelphia: P. Blakiston, Son & Co.

Births, Marriages and Deaths.

At Cobourg, on the 5th ult., Dr. G. W. Mac-Namara, of Tara, to Lilla, daughter of the late Angus Crawford, Esq., Cobourg.

At South March, Ont., on the 12th ult., Geo. H. Groves, M.D., of Carp, Ont., to Fanny, eldest daughter of G. W. Monk, Esq., M.P.P.

On the 19th ult., Geo. A. Kennedy, M.D., Surgeon Mounted Police, Fort Calgary, N. W. T., to Alice Maude, only daughter of Dr. Allen, of Cornwall, Ont.

At Kentville, August 30th, of cirrhosis of the liver, Henry Shaw, M.D., aged 52 years.

In Forest, Ont., on the 10th ult., Cornelius East, M.D. (Trinity), aged 35 years.

On the 23rd of August, Dr. J. B. Campbell, of Westfield, N. Y., formerly of Ontario, aged 38 years.

* * * The charge for notices of Births, Marriages and Deaths is Fifty Cents, which should be forwarded in postage stamps with the communication.

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Original Communications.

CHLOROFORM AS AN ANÆSTHETIC— ITS PHYSIOLOGICAL ACTION AND THERAPEUTIC VALUE.*

BY JOHN J. GAYNOR, M.D., DEBEC, N. B.

It may be well at the outset, in view of its being often forgotten by some surgeons, to call attention to the fact that physiological respiration in man is performed either through the mouth or nasal fossæ, —never simultaneously through both. It is therefore a mistake of the chloroformist to believe that, if the mouth be left open and uncovered during nasal inhalation the patient will inspire sufficient air to dilute the anæsthetic to the standard of safety, or that the holding of the nose during buccal respiration will hasten anæsthesia. Such phenomena could only occur in the presence of peculiar pathological conditions of the soft palate, or pharynx, or of both.

The immediate local effects of chloroformic vapor on the air passages are of a stimulating nature: those portions of the mucous membrane which minister to special sense are thus placed in the highest state of functional impressibility, and, as might be expected, the salivary glands become abnormally active. Large or small volumes of air are usually swallowed with the saliva at this stage; later on we shall enquire why we may also have vomiting. Let us first examine the nervous circle of salivation. Here we find, that through chloroformic stimulation of the glosso-pharyngeal and gustatory end-bulbs a centripetal incitation is generated and conveyed to the gustatory centre in the medulla oblongata, and thence reflected on the auriculo-temporal and chorda-tympani as a centri-

fugal excitation to the salivary glands. The hypersecretion which follows is of short duration, because the nerve cells of the end-bulbs soon become semi-coagulated and unimpressible. It must not, however, be forgotten or overlooked that such a secretion takes place, and that it may accumulate in the pharynx; consequently we should, in any and every case of accident under chloroform, clean out the mouth and draw the tongue forward.

The remaining portion of the respiratory tract shares equally in the general stimulation, and as the volume of carbonic acid gas exhaled during the period of excitement is greater than normal, we thus have a double cause for pneumogastric irritation. This last is translated by increased frequency of respiration, and the patient's usual attempts to displace the inhaler. Tolerance is soon established, but as the mucous and respiratory membranes are sometimes anæsthetized before sufficient vapor has entered the blood current, the respiratory stimulus is often wanting and the patient may forget to breathe. Let us not attempt, as is often done in such cases, to squeeze the wind out of him; such a proceeding invites cardiac syncope. The sense of hearing, owing to the depth at which its encephalic centre is located, is the last to yield to anæsthetics, and without resorting to physical force, we should, in the case in question, simply tell our patient to "breathe naturally."

When impure chloroform is used for inhalation the patient is almost suffocated by the first inspirations, the veins of the neck and face become turgid, the number of respirations diminished, the pause between inspiration and expiration lengthened, the period preceding anæsthesia prolonged, and the risk of cardiac syncope increased. A chloroformization which begins badly will follow a troublesome course, and require marked attention. "Pure chloroform kills only when badly administered." Unless we use a "Snow's Inhaler," Gosselin's intermittent method of administration is the correct one; but we must ever bear in mind that over 5 per cent. of chloroform in the inspired atmosphere is dangerous, and that 10 per cent. destroys life by completely inhibiting molecular interchange.

Having thus far dealt almost entirely with effects due to local stimulation, we will divide complete anæsthesia into four periods, viz.:—(1) Anæsthesia of the cerebrum, cerebellum and basal ganglia;

* Read before the N. B. Medical Society, July 18, 1883.

(2) of the pons variolii ; (3) the spinal cord, and (4) medulla oblongata. This division is based on the order in which the grand centres succumb, because, though the entire nervous sodality is simultaneously affected, the superficial portions of the encephalon yield before the deep, and the spinal cord before the medulla oblongata. Complete anæsthesia must necessarily destroy life by paralyzing the respiratory centre. Surgical anæsthesia corresponds with paresis of the pons varolii and consequently does extend beyond the centres of the "life of relation."

The immediate constitutional effect of chloroform in the circulation is general stimulation—psychical, nervous, muscular, and circulatory—the phenomena of which when taken collectively constitute the period of excitement. This period of inebriation is, however, much shorter than when ether is employed, the patient's struggles not being so violent, nor the volume of air drawn into the stomach so large. Stimulation is rapidly replaced by sedation until surgical anæsthesia is reached, at which time the vaso-motor, cardio-motor, and respiratory centres alone remain capable of performing reflex functions. Here let us add, parenthetically, that the essence of a reflex act consists in the transmutation by the irritable protoplasm of a nerve-cell of an afferent into an efferent impulse. If we now divide the reflex centres into sensori-motor, ideomotor, excito motor, and inhibitory, we will be the better able to follow this rapid growth, and as rapid decline, of nervous irritability. The sensori-motor centres are chiefly situated in the medulla oblongata and spinal cord, and reflex action through these centres places the organs of special sense in a fit state to receive and transmit impressions. Those purely material centres are again connected with their respective ideomotors situated in the convolutions of the cerebrum, and this last connection is apparently the psycho-material telephone between matter and mind. Through it the individual becomes conscious of external impressions ; and were this link destroyed, organic aptitude still remaining, we would have what might be called "ideo-coma." Bearing in mind that the primary action of chloroformic vapor is stimulant, we can readily understand how the circulating anæsthetic excites the conscious centres of special sense, and why those senses are, for a time, more acute than normal. The functions, then, of the cerebral con-

volution being eminently psychical, different areas being the seats of muscular consciousness for different muscular groups, these areas are called into action only when intelligent consciousness and volition are needed. The cerebellum, on the other hand, is the co-ordinating centre of muscular precision for voluntary movements, and the basal ganglia are the semi-conscious centres through which the different impressions are carried and returned from their various conscious and co-ordinating areas. What then might be expected but, that the primary chloroformic incitation of those encephalic centres should give rise to an unusual supply of muscular force, an exactness of muscular movement, and a rapid evolution of ideas, derived in part at least, from immediate external impressions. Should this quickened consciousness, this cerebral power to generate ideas manifest itself in the form of a powerfully depressing emotion, such, for instance, as "fear of instantaneous death," the special centre in which this originates may also generate a motor impulse which, if reflected on the pneumogastric, may inhibit the heart in diastole. In this way only can we account for many of the unexpected deaths which have occurred, without apparently sufficient cause, during the earlier stages of chloroformization.

The above leads us to another consideration. The more thoroughly educated are particular ideomotor centres, the more highly differentiated their constituent nerve-cells, and, as a consequence, the more irritable and rebellious to anæsthetic influence. Now, the cardinal principle in man is self-preservation ; in woman, preservation of the species. Man is aggressive ; woman emotional. As a result of this psychical difference, we generally find that the actions and incoherencies of male subjects during the period of chloroformic excitation are of the combative variety. Women, on the contrary, may display the emotional by singing, etc., but their thoughts and sensations usually run in precreative channels. From this peculiar action on the softer sex, we deduce the practical rule: Never anæsthetize a female excepting in the presence of a third person.

Let us next see what may be learned from the state of the pupil. In the iris we find two sets of muscular fibres, supplied by two sets of motor nerves originating in two different centres. The circular fibres (*sphincter pupillæ*) receive their efferent nerve supply through the motor oculi from the

motor tract of the pons varolii and the corpora quadrigemina; the radiating fibres (*dilator pupillæ*) are supplied by the sympathetic from the ciliospinal centre situated in the spinal cord between the 6th cervical and 2nd dorsal nerves. By irritation or paralysis of one or other of these musculo-nervous mechanisms, contraction or dilatation of the pupil is accomplished. Now, the cerebro-spinal system responds more rapidly to excitation than the sympathetic, consequently, the trophic stimulation of chloroform reaches the sphincter pupillæ before the counteracting sympathetic impulse arrives in the dilator fibres, and the first phenomenon noticed in the pupils is contraction. The equilibrium is soon established, but is of short duration, and as the pons varolii begins to yield, dilatation increases. The rule then is: the pupil is dilated during surgical anæsthesia. When death occurs before surgical anæsthesia has been reached, and when, in this case, we find a contracted pupil, the surgeon not having commenced to operate, death is usually due to the audacious or ignorant chloroformist. He has crowded the vapor on the patient; the blood has been called to the abdominal organs and, as a consequence, this chloroformized blood has paralyzed the sympathetic system. The pupil contracts, and I need scarcely add that death begins at the heart.

When surgical anæsthesia is reached, touching the corneal conjunctiva fails to excite palpebral reflex. This reflex act is, excepting dilatation of the pupil, the last of those of the "life of relation" to disappear, and the time of its abolition is yet far enough removed from the period of toxic accidents produced by chloroformic drowning. On the other hand, returning consciousness is first indicated by the restoration of palpebral reflex in the form of fibrillary contractions of the inferior eye-lid. That contractions can be first awakened in the lower eye-lid is due to its chief nervous supply being from the portio-dura, while the upper eye-lid is, in the greater part, supplied by the patheticus and motor oculi. If, then, we pay attention to palpebral reflex, we can, after anæsthesia is reached, regulate inhalation by suppressing and recommencing according as we cannot or can excite contractions in the lower eye-lid. A minute observation of this phenomenon must not, however, exclude an attentive surveillance of the rhythm of respiration, and general muscular relax-

ation. The difference noticed in the doses required to produce toxic effects in different individuals is chiefly due to personal idiosyncrasy, the purity of the chloroform and the method of administration.

Vomiting is of more frequent occurrence under ether than chloroform. This is in a large measure due to the more grateful odor of chloroformic vapor, and the comparative shortness of the period of excitement. When vomiting occurs in the primary stage of inhalation, it is produced by pharyngeal reflex and is accompanied by nausea due to cerebral anæmia. The chloroform which produces such vomiting is dangerously impure and should be at once discarded; it will assuredly produce cardiac syncope by trifacial or superior laryngeal reflex. A less impure article will usually produce vomiting during the anæsthetic stage, though here the amount of air which has been swallowed plays a part. This air irritates the terminal fibres of the gastric plexus, and by reflex through the vomiting centre, the phrenic nerves stimulate the diaphragm to fixity, and the vagi produce expulsive efforts of the stomach. Nausea is absent. Pure chloroform seldom produces vomiting, provided the patient's stomach be empty. Let us then order our patients not to eat any solid food for twelve hours, or swallow liquid food for four hours before we commence to operate. Of course, we do not include in this last category the usual glass of brandy which, if given, should be administered immediately before placing the patient on the operating table. Furthermore, we should prescribe gargles of bromide of potash to lessen pharyngeal susceptibility, and use only pure chloroform. With these precautions vomiting is generally avoided, and this alone is a matter of much moment, especially in abdominal surgery.

Chloroform anæsthetizes by producing a temporary sclerosis of the afferent nerve-cells of the cerebro-spinal system, and by inhibiting the molecular interchanges of animal chemistry. It is however an open question as to whether the motor nerves of animal life are affected by chloroform, but from its action on the heart it would appear that the organo-motors are, at least, rendered paretic. Anæsthesia commences at the periphery and proceeds towards the animating and co-ordinating centres of animal and organic life. Owing, however, to a more liberal nerve supply, some portions of the integument are more hyperæsthetic

than others. Thus, in surgical operations on the external organs of generation, particularly in females, we find that reflex action may be excited in the parts, though the remainder of the periphery of the trunk be anæsthetized. Anæsthesia, in these cases, needs be as profound as if we were going to amputate below the elbow or knee joint.

Confirmed alcoholics are more or less refractory to anæsthetics, and in reducing old luxations on those subjects we are often unable to obtain complete muscular relaxation by confining ourselves within the ordinary limits of surgical anæsthesia. One reason for this is, that the cortices of the motor centres having been previously hardened by alcohol, are not as rapidly affected by chloroform.

The antispasmodic properties of chloroform are of signal service in poisoning by strychnia or brucia. The tetanic convulsions, opisthotonos and fixation of the diaphragm, in these cases, indicate an exalted reflex irritability of the spinal cord. Anæsthesia destroys this hyperæsthesia and relaxes the clonic spasm of the respiratory muscles—a spasm which produces death by apnoea. Chloral hydrate, potassium bromide, Calabar bean and nicotia are usually recommended as physiological antidotes to strychnia, but chloroform by inhalation is our main reliance. We of course advise that tannin be administered, the stomach evacuated whenever it is possible, but the respiratory spasm must be relieved and kept in subjection.

Inhalations of chloroform have become classical in the treatment of puerperal eclampsia, but to elucidate, if possible, the rationalé of this medication we needs must make a cursory etiological survey. Here, then, whether anasarca or albuminuria be present or otherwise, we are supposed to find an excess of urea in the blood, and many believe that the convulsions of puerperal eclampsia are due to the action of the carbamide on the nerve centres. Late French experimenters, however, assert that there is no such thing as "uræmia," that what has generally been accepted as uræmia, should be called "potassæmia," that the potassium salts are present in excess in the blood current of uræmic patients, and that toxic injections of potassium salts will produce what, up to the present, has been known as uræmic poisoning. We cannot accept either explanation, because we cannot hide from ourselves the broad fact that under the influence of intra-venous injections of

any alkali, carbonic acid gas is so rapidly evolved into the blood current, that the pneumatic acid of the lung tissue cannot liberate the whole volume of the carbamide, and as a consequence, the comatose condition which we meet with in uræmic poisoning is induced. Then, too, coma and eclampsia are not synonyms. In candidates for puerperal eclampsia, we find a partial or complete suppression of urine with a uriniferous, ammoniacal odor evolved from the body and excretions; convulsions follow if the suppression is not relieved. Now we cannot produce convulsions by subcutaneous injections of either normal urine, or ammonium carbonate, but by a mixture of both, or by a subcutaneous injection of ammoniacal urine we can readily simulate an attack of eclampsia. Thus, then, it would appear that by the retention and re-absorption of the products of dis-assimilation, the urea of the blood current is decomposed into ammonium carbonate and carbonic acid, and a urino-ammonæmia generated. During pregnancy, too, the nervous system is continually storing up a reserve force to carry the patient through the parturient act, and the urino-ammoniacal products, by directing this latent energy in improper channels, give rise to that state of exalted reflex irritability which we call "puerperal eclampsia." Chloroform fits in here like a statue in its niche. The anæsthetic, by irritating the diabetic centre in the medulla oblongata, produces glycosuria. This glycosuria, in turn, prevents the further decomposition of urea and aids the system to overcome the morbid effects of misdirected animal chemistry. Thus, then, the good effects of muscular relaxation are not the only gains from administering chloroform in puerperal eclampsia.

Since the British queen, while giving birth to her eighth child in 1853, forced her accoucheurs to give her chloroform, the practice has become fashionable, especially in England. It has been urged that we thus silence the pains of labor, and that those pains are necessary to the expulsion of the child, consequently we should not administer the anæsthetic. One moment's reflection will show us that the terms "pain" and "uterine contraction" are not synonymous. In fact the pains of the first stage of labor are usually referred to the lumbar portion of the spine, and ice-bags placed in this region will relieve the pain without retard

ing the labor. Chloroform is often administered at this stage, but surgical anæsthesia must not be produced; our objective points being to blunt susceptibility and relax a rigid os uteri. This accomplished, then we must cease: if we do not, we will produce complete relaxation and invite post-partum hæmorrhage. In ordinary surgical cases, however, hæmorrhage is lessened by using chloroform as an anæsthetic, but the accoucheur cannot avail himself of its coagulating properties. The reason of this is in part anatomical: the maternal arteries and veins at the placental site are not connected by capillaries. The pains of the second stage of labor are generally due to forced dilatation of the soft parts, and it is at this time that we usually administer chloroform. The method should be intermittent, that is, we should remove the inhaler as soon as the pain has passed off. A sort of numbness of the parts is all we wish to obtain, and this point reached is quite sufficient.

After the preliminary increase of arterial tension produced by chloroform, the circulation becomes slower, the leucocytes oscillate and are arrested first in the capillaries, then in the arterioles, and finally in the larger vessels. The red globules agglomerate and form *maggæ*, which disappear when the pulsations become normal. The blood-vessels, owing to the absence of vaso-motor impulse, become constricted in calibre, and if anæsthesia be carried beyond surgical limits, vascular areas, which were well marked when the circulation was active, grow paler and are gradually effaced. This last explains why cessation of hemorrhage is a signal of danger. Those coagulating and constricting properties, however, recommend chloroform as *the* anæsthetic in all operations on the eye. The same, too, has been turned to advantage in connection with Esmarch's bandage in the treatment of external aneurisms.

The number of deaths which have occurred under chloroform, and I may add ether, under the first stroke of the surgeon's knife, leads us to inquire—Is it or is it not better to commence to operate before surgical anæsthesia has been obtained? The gravest accidents from anæsthetics are cardiac and respiratory syncope, but each form is brought about by an entirely different mechanism. Cardiac syncope is the result of a complete reflex act, and is by far the graver of the two. The mechanism of production is the following: Through

shock to a sensitive nerve-fibre, a centripetal impression is carried to the rachidian bulb and there transformed into a centrifugal current which, on passing down the vagus, inhibits the heart in diastole. What makes cardiac syncope so dangerous is that the heart is already too feeble to empty its ventricles at each systole, the excito-motors of the heart are not in a physiological state, and are so thoroughly overpowered by vagus inhibition that they fail to respond. To use an Americanism—The excito-motors of the heart come up groggy, and are "Sullivaned" by the first pass, which causes powerful vagus inhibition. Let me correct what was an error in practice by saying, that vagus inhibition may readily be produced by faradization of the phrenic nerve by an electrical shock to any portion of the periphery, the patient being under chloroform; consequently, in either form of syncope, we should never employ the faradic current. From the foregoing data we must conclude that we should never commence to operate until surgical anæsthesia has been reached. Surgical anæsthesia may be defined as loss of consciousness, complete abolition of sensibility, of voluntary movements, and of reflex action in the nerves of the "life of relation." To guard more carefully against cardiac syncope, it is our duty to give our patient, before placing him on the operating table, a hypodermic of atropine as a vagus paralyzer, and, if you wish, a glass of good liquor as a heart stimulant. With these precautions and with pure chloroform properly administered, there is no danger of cardiac syncope, or contra-indication from heart disease.

In respiratory syncope the centripetal excitation is carried to the rachidian bulb and there arrested. The reflex act is not completed. Centripetal excitation is not transformed into centrifugal incitation. It is usually due to anæsthesia being too profound, and as a rule can be overcome by resorting to artificial respiration. As patients under morphine require less chloroform to produce anæsthesia, a hypodermic of this alkaloid is indicated as a prophylactic against respiratory syncope. Our hypodermic, then, should contain—morphia $\frac{1}{8}$ gr., atropine $\frac{1}{60}$ gr.

I can best conclude this paper by giving as a *résumé* the following practical rules of procedure, which I take from the *Gazette des Hospitaux*, of Paris:—

1. The compress is to be preferred to all other

means; a handkerchief is to be had everywhere and alarms the patient less than anything else. 2. Fold the handkerchief into the form of the mouth of a horn, and keep it closely pressed against the point of the nose, but pour the chloroform only on the part of it which is not directly in contact with the skin. 3. Its application should be intermitted, but this need not be done in the precisely regulated manner recommended by Prof. Gosselin. 4. Give very little chloroform at the commencement, in order to accustom the patient to it, and prepare him for the feeling of suffocation. Then when the first inspirations are over, pour on the chloroform very often, otherwise much time will be lost, and complete anæsthesia obtained with difficulty. 5. Before commencing the application, take care that no article of dress constricts the patient, removing even the string of a cap. 6. Expose the epigastrium, and from the very commencement keep the eye on it, and *constantly* watch the respiration without caring about the pulse. 7. Always have a forceps within reach. 8. As soon as the respiration becomes noisy and stertorous, remove the compress and allow the patient to breathe fresh air for a time. 9. When respiration is arrested, seize the tongue with the forceps and draw it out, and immediately commence artificial respiration. If the respiration is not re-established after a few minutes (seconds), place the head low, forcibly flagellate the cheeks, keep the tongue out, and continue the artificial respiration for five, ten, fifteen, or even twenty minutes, if necessary. 10. When respiration is noisy, pass into the back of the throat a sponge mounted on a forceps, in order to remove the mucus existing there, as they frequently do in patients suffering from colds. 11. There is but one contra-indication to the employment of chloroform, viz., advanced phthisis. Affections of the heart are not contra-indications. 12. Hysterical subjects should be distrusted. 13. Alcoholic subjects are very tedious and difficult to bring under the influence of chloroform, but they are not dangerous.

GASTRORRAPHY AFTER GUN-SHOT WOUND OF THE STOMACH.

BY P. MANSON, M.D., VIRGINIA CITY, NEV.

I was called in haste on August 3rd, 1883, to see J. F., æt. eleven years, who was accidentally

shot at a foot race from the careless handling of a large-sized forty-four calibre revolver in the hands of another party. I arrived about twenty minutes after the accident; Dr. Hall was also in attendance a few minutes before me. We found the patient suffering intense agony, with two large external wounds. The aperture of entry was on the left side, between the tenth and eleventh ribs, and the aperture of exit in the centre of the linea alba, an inch below the ensiform cartilage. From the latter wound there was a protrusion of omentum with slight discharge of bloody fluid, which seemed to have come from the stomach or upper intestines. Gas was also occasionally escaping from the anterior wound. The pulse was good.

It was very evident that there was a perforating wound of either the stomach or intestines. We suspected the stomach, from the fact that the course of the ball between the two external wounds would be in close proximity to that organ. There were frequent efforts at vomiting, but nothing ejected by the mouth except a little mucus, notwithstanding he had shortly before eaten his lunch. In consultation we were agreed that there was perforation of some of the abdominal viscera, with extravasation into the peritoneal cavity. We advised enlarging the external wound, suturing intestinal or gastric lesions and cleansing the peritoneum of any foreign matter, as being the treatment that would place the patient in the most favorable condition for recovery. The boy's parents had not arrived, consequently we had to wait until they came. In the meantime we tried to relieve the patient's suffering by hypodermic injections of morphine, and to sustain his strength by hypodermic injections of brandy. His father who was at work some three miles distant arrived in about three-quarters of an hour. We stated the nature of the case to him, advising the operation as being the only treatment that would place the boy in any possible condition to recover. He hesitated to give his consent to such an operation, and as time was precious we suggested that more counsel might be agreeable to him under the circumstances. At his request Dr. Bronson was called in. After examining the case he at once agreed with us as to the course of treatment. The mother having in the meantime arrived, both parents were reconciled to leave the case in our hands. The morphine, one-eighth grain hypodermically, had not given

any relief. The poor fellow's suffering was intense. During the past hour his pulse had failed considerably. Spirits good. After placing the patient under chloroform, we made an incision from the lower edge of the anterior wound down the median line, sufficiently large to allow a thorough exploration of the cavity, causing the protrusion of some of the small intestines and the discharge of about a pint and a half of bloody fluid from the peritoneal cavity, mixed up with a quantity of half-digested food. In searching for the cause of this extensive extravasation, we found an extensive laceration two and a half inches long through the anterior wall of the stomach, to the left of the median line, corresponding with the course of the ball, allowing the contents of the stomach to escape into the peritoneal cavity. We could not find any other wound perforating the stomach or bowels. The bullet had passed along the wall of the stomach, laying it open without entering its cavity, passing out at the mesial line. The peritoneal cavity was carefully cleansed, the escaped intestines returned after all foreign matter was removed, and the rent in the stomach closed by continued suture and also secured to the external wound, in hopes of getting additional adhesions to the abdominal wall and more thoroughly preventing any further extravasation into the cavity. The external wound was then closed, dressed, etc.

Our little patient stood the operation well and expressed himself as feeling comfortable. He was now free from pain and vomiting. Before and during the operation he was making frequent efforts at vomiting, but only vomited once afterwards. All that he now complained of was excessive thirst, which continued until his death. The operation did not increase the shock as much as might have been expected. However, his strength continued to fail until three o'clock the following morning, eleven hours after the accident, when he became unconscious, arms slightly convulsed, and died at half past three.

Although this case proved fatal, as all other cases of the same nature have done, still I think that in cases of gun-shot or incised wounds perforating the stomach or bowels, it goes far to show the importance of enlarging the external wound, suturing perforations, and thoroughly removing all foreign matter, not trusting to luck in these cases. What possible chance had this boy to recover

with a rent in the walls of the stomach two and a half inches long, and the contents of the stomach emptied into the peritoneal cavity, without an operation of this kind? And what could be expected from an expectant plan of treatment in a case like this, but the death of the patient? The operation certainly placed this patient in the most favorable, in fact, in the only condition possible for him to recover. In our treatment we were only carrying out the rule in surgery: that no matter how severely the patient is injured, treat him or her as if you expected recovery. In the future, should I be called upon to attend a case of shot or punctured wound of the stomach or intestines, where there was reason to believe that there was extravasation of fecal or other matter of a dangerous nature, I would not hesitate to recommend the same treatment. In *Gaillard's Medical Journal*, January 13th, 1883, there is an article by J. Marion Sims, copied from the *Brit. Med. Journal*, strongly advocating the importance of enlarging the external wound in all cases, whether shot or punctured, and searching for injured bowel and suturing lesions, and permit me to copy the following quotations from Dr. Sims, giving the opinions of some eminent surgeons on this subject. Otis says of shot-wounds of the small intestines of any magnitude, "the pathological evidence of recoveries achieved by the unaided efforts of nature, even through the establishment of a preternatural anus, is limited to very few instances, of which none are absolutely unequivocal. Therefore, in wounds of the viscera unattended by protrusion, when there is danger of extravasation, the external wound should be enlarged and the wound in the intestine closed by suture."

Dr. J. S. Billings says, in a letter to Otis: "In regard to penetrating wounds of the abdomen where there is reason to suspect intestinal injury, it appears to me to be proper to enlarge the opening, if necessary, to ascertain the nature and amount of injury, to remove foreign bodies and extravasated matter, to employ sutures or ligatures where needed and to cut these short and return the injured viscera. Especial care should be taken to prevent even the smallest particle of fecal matter from escaping into the peritoneal cavity and to remove such as may escape."

Professor Hunter McGuire expresses himself thus: "Penetrating wounds of the belly are nearly

all fatal, and we must look for some other means of saving life than we now have. If the shock, thermometer, etc., indicate wound of the bowel, cut down and sew it up. You say this is desperate. I answer, the cases justify it. We must do something more than give opium and use ice-poultices."

Dr. H. S. Hewitt says: "It is next to an impossibility when a soldier is wounded in the abdomen, with lesion of the intestines, that their contents should not escape into the peritoneal cavity. I think it admits of question, whether greater effort should not be made to seek out the wound, to close it with silver wire and to endeavor to obtain primary union, while peritonitis and constitutional disturbances are treated on general principles."

Professor N. S. Lincoln declares that, "In punctured and incised wounds, when there is adequately strong presumptive evidence of intestinal lesion though there may be no protrusion, it is the surgeon's duty to enlarge the parietal wound to seek for the wounded intestine, and to close the orifice, if it exceeds three lines, by suture. That in shot wounds of the intestines unattended by protrusion, unless the perforation may be in the iliac region with a reasonable likelihood of implicating the part of the large intestine uncovered by peritoneum and thereby avoiding the risk of intraperitoneal extravasation, it is the safest course to enlarge the tract of the ball and to close the intestinal wound by suture."—[Letters from Drs. Billings, McGuire, Hewitt and Lincoln to Otis, published in "Medical and Surgical History of the Civil War."]

Prof. S. D. Gross says, "When we reflect on the fact, that in all lesions of this kind the great danger is from fæcal effusion and that such effusion is almost inevitable even when the opening in the intestine is of very small extent, the duty of the surgeon, I think, plainly is to enlarge the abdominal orifice, to seek for the wounded tube, and to sew up the cut in the usual manner."

Dr. Sims in his article says, "I would therefore insist in leaving nothing to luck, but to explore and suture all intestinal and bladder wounds alike, under all circumstances." He further says, "In the treatment of perforating shot and other wounds of the abdomen, we should strictly observe the following rules:

"1. The external wound or wounds should be

enlarged as soon as possible and sufficiently, to ascertain the whole extent of the injuries inflicted.

"2. These should be remedied by suturing wounded intestines and ligaturing bleeding vessels.

"3. Diligent search should be made for extravasated matter, and the peritoneal cavity should be thoroughly cleared of all foreign substances, whether fæcal or bloody, before closing the external opening.

"4. The surgeon must judge whether the case requires drainage or not. Generally it will not, if the rules be strictly carried out. We must not forget that fæcal effusion has taken place after intestinal wounds have been sutured, simply because the surgeon failed to find and suture all the lesions. And we must not forget that fatal results have followed enterorrhaphy when thoroughly done, simply because fæcal effusion had taken place before the intestine was sutured and had been left in the peritoneal cavity, producing death as speedily and as certainly as if the lesion had not been found and closed. Therefore it is essential not only to find all lesions and remedy them, but to be sure that we leave the whole cavity of the peritoneum perfectly clean."

REPORT ON MEDICINE, MATERIA MEDICA, AND PHYSIOLOGY.

(Ontario Medical Association, June, 1883).

BY A. HAMILTON, M.D., PORT HOPE, ONT.

THE TUBERCLE BACILLUS.—Within two years, Koch, of Berlin, announced his discovery of a specific cause for pulmonary phthisis in the tubercle bacillus. There being too large a supply of credulity in the ordinary medical mind, this was too readily accepted. Many rushed off to carbolic acid as the specific in therapeutics. The other side of the question has now been heard from. It comes from the Vienna school. Dr. Spina, who has long been chief assistant to Stricker, and whose capability cannot therefore be questioned, maintains, as the result of his observation, that the form of the bacillus is variable, such variations depending on the tissue and the local conditions. The objection is a fatal one, if the variation of form be considerable. The form of a specific animalcule in general has a fixity, by which it is known. Considerable

variation in this shows, unless otherwise explainable, that it is not an animal entity, and so destroys it as a specific cause. From a practical stand-point, Koch's theory has received a severe blow in two cases which have recently occurred at Nothnagel's clinic. In both cases tuberculosis was diagnosed, because bacilli were found in the sputa. Post mortem examination showed them to be examples of bronchiectasis; no tubercles were found at any point. Dr. J. Dreschfeld (*Brit. Med. Jour.*, Feb. 17th) holds that they are absent in non-tubercular chronic pulmonary affections (bronchiectasis, emphysema, fibroid pneumonia, anthracosis, catarrhal pneumonia, and syphilitic disease of the lungs). The probable end of Koch's theory is likely to be laid on the shelf beside the parasitic etiology of diphtheria, and that the verdict upon both will be that cause and effect have been mistaken. The secretions become putrid from heat and the bacilli are there naturally developed as part of the process of decay; they are not causative at all. Satterthwaite, in a paper before the N. Y. Academy of Medicine (*Med. Record*, Oct. 28th, '82), and subsequent discussion, shows that we have not yet sufficient grounds for believing in the bacillary and infective nature of tuberculosis, but that bacilli of a peculiar nature were frequently to be made out in phthisical sputa.

MYXÆDEMA.—Dr. A. McL. Hamilton's article (*N. Y. Med. Record*, Dec. 9th, '82) is a valuable summary of the principal papers upon the newly described clinical entity, myxœdema. He is inclined to the view that the disease is dependent upon a "lesion, primarily, of the bulb, with secondary extension to the postero-lateral columns of the spinal cord and the sympathetic ganglia." He thinks that an associated renal disease is the result and not the cause of the myxœdema.

BY J. GILLIES, M.D., TEESWATER, ONT.

CONVALLARIA MAIALIS, or Lily of the Valley, is a new remedy for heart disease. The active principle is an amorphous bitter glucoside, called convallamarin, obtained by treating the aqueous extract of the flowers by alcohol and chloroform. Dr. Sus' conclusions are as follows:

1. It is one of the most active cardiac remedies.
2. In doses of from $\frac{1}{2}$ to $1\frac{1}{2}$ grammes daily of the aqueous extract of the entire plant, it produces

on the heart, blood-vessels, and respiratory organs effects constant and constantly favorable.

3. It produces copious diuresis.

4. Therapeutic indications:—(a) In palpitation due to exhaustion of pneumogastric. (b) In simple cardiac arrhythmia, with or without hypertrophy, with or without valvular lesions. (c) In mitral constriction. (d) In mitral insufficiency, especially when there are pulmonary congestions. (e) In Corrigan's disease, the peripheral arterial pulsations disappear and respiration becomes markedly restored. (f) In dilatation of the heart, with or without (1) hypertrophy, (2) fatty degeneration, (3) muscular sclerosis. (g) In all cardiac affections, indifferently, from the moment that watery infiltrations appear, it is prompt and certain in its action. (h) In lesions with dyspnoea, the effect is less marked. In cardiac asthma, in combination with iodide of potassium, it is most useful. Finally, in cardiopathies with dropsy, the convallaria surpasses all other remedies. It has no deleterious effect and no cumulative action.

Some efficient drug having the action claimed for convallaria is certainly a desideratum in practical medicine.

ADONIS VERNALIS.—Dr. Bubnow believes that adonis is positively preferable to digitalis in cases of organic heart disease; and he finds that, like the convallaria maialis, it is not cumulative in its action. It belongs to the Ranunculaceæ.

VIBURNUM OPULUS.—Hall recommends high cranberry as a powerful anti-spasmodic. It is known among American practitioners as Cramp's bark. It is said to be very effective in relaxing spasm and cramps of all kinds, as asthma, hysteria, cramps of the limbs and other parts during pregnancy; but it is in spasmodic dysmenorrhœa that it seems especially indicated. Hall prescribes a few drops of the tincture for a week previous to the expected time. When the pains begin he gives it every half hour, and if severe, every quarter hour. According to Hall, in neuralgia and spasmodic dysmenorrhœa it has yet to meet with a single case which it has failed to cure.

CAFFEINE IN HEART DISEASE.—Prof. Lepine claims that caffeine is as efficacious as digitalis in retarding the heart's action and in increasing its force. In comparing the relative merits of the two drugs, he asserts—

1. It acts more rapidly than digitalis, and in fatty heart where the latter is contra-indicated, there is no doubt but that it does good.

2. It is tolerated better than digitalis.

3. Most patients prefer it to digitalis.

Where caffeine produces insomnia it is contra-indicated. To produce benefit the dose must be from 9 to 30 grains.

IODOFORM.—Iodoform is highly recommended in diphtheria. The manner of using it is as follows: It is applied locally to the patches in its purity, with a camel's hair pencil, every two hours. Others use it by spray, in the aqueous solution; in this way it corrects fetor. According to Billroth, we possess no antiseptic, not excepting carbolic acid, that is so trustworthy in making a foul wound sweet.

It is affirmed and denied that it possesses anti-tuberculous properties. It has an influence almost specific over tuberculous swellings and ulcerations. Dr. Henry claims to have cured a number of cases of tonsillar hypertrophy and ulceration by iodoform spray. Its odor is an objection to its extensive use.

BY H. MCKAY, M.D., WOODSTOCK, ONT.

PHYSIOLOGY seems to be recovering from the concentration of effort put forth at the International Medical Congress in 1881. In spite of the anti-vivisection embargo, the past year has shown advances, although chiefly on the old lines.

The Spleen a Portal Heart.—Dr. C. S. Roy has further developed his discovery that the spleen is the seat of perfectly rhythmical contractions and dilatations, independently of cardiac and respiratory movements. That in fact the spleen may be regarded as "a portal heart." This appears to be a new and important fact in physiology.

The Heart's Action.—Cardiac physiology has received a good deal of attention and a new impulse has been given to the innervation and mechanical movements by the opportunity afforded for observing the effects of stimuli directly to its substance in the case that occurred lately in Germany, examined by Ziemssen. A woman, æt. 45, had a tumor removed from the anterior wall of the thorax, which left the two ventricles and part of the left half of the diaphragm exposed. The following conclusions have been formulated: 1. That the contractions are evoked by the stimulus of alkaline blood to its mucous membrane (?), act-

ing through the ganglia of the sympathetic which are in connection with the vagus. 2. That their rhythmical character ultimately depends upon the peculiarity of the muscular tissue; and, 3. That the compensating rest of the heart is due to the nervous structure which might be represented as opening and closing the current.

Important information has been published on "The mean pressure and characters of the pulse wave in the coronary arteries," which appears to settle the question in favor of those who believe "the coronary arteries injected during the systole of the heart and not during the diastole. It is obvious the influence this would have on the nutrition of the heart in valvular lesions.

During the year important additions have been made to our knowledge of the composition of blood, as the discovery of a third or transparent corpuscle; the use of the hæmatocytometer facilitating calculations as to the absolute number of corpuscles in the medulla of bones; also that the white corpuscles contain a ferment that plays an important part in fermentation.

"The location of cerebral function" has occupied much attention, as also "Cross-action of the cerebral nerves."

Dr. Brown-Sequard writes that he is "convinced that irritation of the base of the brain and the adjacent motor regions causes convulsions more frequently on the side irritated than on the other. The superficial parts of the brain produce chiefly cross-convulsions, but irritation in all parts may cause convulsions on the same side, and that the chief foundation for the theory of psycho-motor centres and of the cross-functional relation between the hemispheres and the limbs must be considered to have lost its value; and that the excitor-motor zone of the cerebral surface, and indeed all the excitable parts of the brain, are capable of putting in action the limbs of the same side as well as those of the opposite." This is high authority for an opinion which no doubt will cause surgeons to hesitate before resorting to operative procedure in such affections as epilepsy, paralysis, etc., which it was supposed would be a sufficient guide to indicate the primary lesion or seat of disease.

Function of the Sympathetic.—The sympathetic nervous system, while closely connected with the cerebro-spinal, yet appears to have an independent action of its own. This is well illustrated by the

fact that the foetus may arrive at the full time with ample perfection of the functions of organic life, while without any trace of brain or spinal cord. Observations also lead to the conclusion that the sympathetic enters largely as a factor into all functional and organic diseases. Dr. F. L. Fox, in his Bradshawe lectures, lately delivered, showed that Dr. Woakes' idea that the "inferior cervical ganglia is a correlating nerve centre," may be expanded thus: the influence of emotion may be seen on the cervical ganglia (blushing), on the cardiac nerves (palpitation), on the splanchnic, on the abdominal plexus, and especially on the vesical ganglia. He has also shown that, although the sympathetic may not be considered as a cause, it is a chief factor in inflammation by causing dilatation of the blood vessels.

BY W. MORTON, M.D., WELLESLEY, ONT.

ABORTED TWIN PREGNANCY.—The accompanying specimen, manifestly that of a human foetus in the early weeks of its development, was passed from the vulva by a married woman, æt. 26, without pain, or other premonitory warning, at the breakfast table and unexpectedly. Seven or eight months thereafter she gave birth to a child at full term. The question arises: Is it a case of twin intra-uterine pregnancy, one of which aborted? like the small green apple falling from its fellow. The last catamenial period terminated on March 11th, 1882. Coitus occurred on March 13th, and again on March 29th and at no other time in the interval. The foetus was expelled April 10th. Delivery of a healthy and fully developed female child occurred on December 20th, 284 days after the last catamenia, and 254 days after the abortion. This specimen is presented by Dr. Wm. Morton, of Wellesley, who states that, having been intimately acquainted with the family for years, he can vouch for their veracity and intelligence.

IMMUNITY FROM INFECTIOUS DISEASES.

BY PROF. R. RAMSAY WRIGHT, M.A., B.Sc., UNIVERSITY COLLEGE, TORONTO.

Review, translated and condensed, from *Biologisches Centralblatt* for September.

I. A New Theory of securing Immunity from Infectious Diseases.

II. The Etiological Therapeutics and Prophylaxis of Pulmonary Tuberculosis.—H. Buchner, Munich and Leipzig, Oldenbourg, 1883.

The above-named *brochures* of Buchner have so much in common with each other that they may be discussed together. Buchner sees in the recognition of fungi as the cause of certain diseases, the greatest triumph which medical science has achieved in our century, but finds that the practical therapeutical consequences of the theory have been so far only very incompletely deduced. The attempts in this direction have hitherto been made in false directions—they either strive after protective inoculation, or direct combating of the fungi by the employment of antiseptics. It appears to be impossible to protect against all infectious diseases by inoculation; at any rate, it would be simply instituting a lesser evil for a greater. The internal use of antiseptics again is positively hurtful, for the poisonous action of antiseptic materials affects the tissues much earlier and more intensely than it does the much more resistant fungi. The very numerous cases of spontaneous cure of infectious diseases show, however, that there are circumstances under which the progress of a fungus-vegetation in the body is rendered impossible. Therefore it ought to be easy enough under favorable circumstances to prevent the beginning of such a vegetation, *i.e.*, to secure immunity. What means does nature adopt in her struggle, so generally successful, against the invasion of fungi? According to Buchner, inflammation is the weapon of the organism in such cases. The correctness of this view is established by an experiment made in 1877, which, however, he has not since repeated: A thread, impregnated with decomposing meat-decoction, was drawn through the middle of a rabbit's ear. When in a few hours the place in question was inflamed, the carotid of the same side was ligatured, and some of the same fluid then injected subcutaneously into the upper part of the ear. The result of these operations is gangrene of the ear; the gangrene, however, extended only over that part of the ear situated above the area of inflammation—the *part inflamed* proved itself an impassable barrier to the bacteria, so much so that the tissue lying below it remained unaffected. The inflammation caused in the first place by the bacteria is thus a self-protective reaction on the part of the organism, and in each case the question

will only be, whether the inflammatory reaction can take place in the desired way, or whether the fungus-vegetations are so vigorous that they push aside the tissue cells and prohibit the inception of the reaction.

From this point of view Buchner attempts to answer the interesting question how it is that immunity from an infectious disease is conferred by a previous attack. The theories hitherto proposed he considers insufficient; he pictures to himself the process as follows:—When pathogenic fungi get in anyway into the circulation, they are carried by the blood into the different capillary plexuses, where they remain, endeavouring in struggle with the tissue cells to effect a settlement. The different kinds of tissues will, however, conduct themselves differently in relation to any particular fungus. Most fungi will be able only to survive the competition in one kind of tissue, but will perish in all others. In this one tissue the reactive inflammation will develop itself. This leaves behind it a permanent alteration which prevents a second invasion of fungi; and as the organ in question is the only possible channel of entrance for them, the purely local alteration is thus the cause of the immunity of the whole organism.

Buchner's reviewer (G. Kempner, Berlin) points out that many known facts range themselves against this explanation (*e.g.*, the tendency towards recurrence of erysipelas), but considers Buchner's suggestion as to inflammation protecting tissues against the invasion of bacteria, well worthy of attention and experimental investigation.

Buchner believes that nature's curative process may be imitated by the administration of arsenic, which in small repeated doses produces the first stage of inflammation in the tissue cells, *i.e.*, increased nutrition and activity, in which condition they are better fitted to engage in a struggle with invading bacteria. Buchner has found arsenic of the greatest service in tuberculosis; he gives daily 10 mg.* of a watery solution of acidum arseniosum 1 to 2,000, attaining this dose in a few days. He believes the therapeutic value of arsenic in malaria, skin diseases, &c., to be also due to its property of exciting inflammation.

*10 mg. = 1·7 gr

"One science only will one genius fit;
So vast is art, so narrow human wit."

TREATMENT OF HYDROCELE AND NÆVUS.

BY THOS. R. DUPUIS, M.D., ETC., KINGSTON, ONT.

I find hydrocele of the tumia vaginalis testis a comparatively common disease, and being very annoying on account of the inconvenience and deformity which it entails on the sufferer, it is desirable to have a quick, safe and efficient cure.

Several methods have been in use at different times and places, such as incision, excision, actual cautery, seton, and injection of the sac with various liquids after evacuating the fluid.

I have tried incision, the injection of iodine after tapping, the seton without first evacuating the contents, as recommended by Henry Smith, and the seton after evacuation of the contents, as recommended by Prof. Gross, of Philadelphia.

By each of the foregoing methods I have secured radical cures, but with varying degrees of trouble, the last one having proved, in my hands, the most speedy and certain. I have operated on hydroceles containing very various quantities of fluid, the greatest being 3xxviii., and the smallest from 3iii.-iv., and I have no reason yet to substitute any other method for that of the seton *after tapping*.

In operating to cure a very large one, I should first simply tap and evacuate the contents, and allow the sac time to partially fill again before ultimately tapping and inserting the seton. The reason for this is obvious. The method of using the seton which I am now advocating, is best given in Dr. Gross' own words: "The operation which I prefer to every other, both on account of its simplicity, its freedom from danger, and its never-failing certainty, is performed in the same manner as by injection, except that the puncture is made a little lower down. After all the water has escaped, the canula is pushed on towards the superior part of the scrotum, where a counter-aperture is made by the re-introduction of the perforator. The instrument being withdrawn, a piece of braid, or narrow strip of muslin is passed through the canula by means of an eyed probe. The operation is finished by removing the canula, and tying the ends of the seton loosely in front of the scrotum." . . . "Let the seton remain for twenty-four to forty-eight hours, or until the scrotum is quite hard, and at least one-fourth as large as be-

fore the operation. The part should meanwhile be well suspended, and the patient kept on his back. For the first few days after the removal of the seton, fomentation of acetate of lead and opium are the most eligible, and these may be gradually, but cautiously, succeeded by spirituous lotions, dilute tincture of iodine, or mercurial ointment. The cure is usually completed within a fortnight." Dr. Gross states that he has performed this operation many times, and has never known it to be productive of any ill effects, and to this testimony I can also add my own limited experience, and say positively that I have never witnessed any bad results from it. In not over three cases, too great an amount of inflammation has retarded the cure, but in every one of these the patient himself, and not the operation, was to blame. In one instance the patient walked a distance of ten miles the second day after the operation; in another the patient, immediately after the operation rode home, a distance of thirteen miles, and then went to choring about his farm; in the third the seton was left in the scrotum too long a time, namely, about four days.

They all got perfectly well, however, although their recovery was somewhat delayed. But accidents like these might happen after any method of operating, and perhaps with less favorable results.

I have used this method almost exclusively in hospital for the last five years, and in my private practice for about ten years, having several times used it where an injection of iodine had failed, and all that I have operated upon have so far remained perfectly free from any return of the disease. I think so much of this plan, that in my clinics at the Kingston hospital for the last four years, I have recommended it, to the exclusion nearly of all other means.

My apology for publishing this simple article in your columns is, that in conversation with other surgeons, I have found many who have never practised this operation, and some who have never heard of it, and believing this to be the best operation known, taking everything into consideration, I am persuaded that it is not amiss to direct attention to it in this manner. I may say in conclusion that other things besides these mentioned may be used for a seton, as a piece of silk twist, two or three coarse linen threads, or a piece of small twine.

Some of your readers may remember the case of a child eight months of age, with a *nævus* upon its upper lip, which I presented to the surgical section of the Canada Medical Association, Kingston, in Sept. last.

The tumor was about the size of a ripe cherry, situated to the left of the mesial line, and midway between the ala nasi and the margin of the lip, forming a purplish, semi-globular projection externally, and causing a bulging of the mucous membrane internally, and becoming tense and more marked in color when the child cried. I knew very well that small and large *nævi* admitted of different modes of treatment, but my mind was unsettled as to the propriety of removing this by excision, and hence I was desirous of getting the opinions of several experienced surgeons respecting the best treatment of this particular case. Nearly all that examined it, agreed that cutting it out would be the quickest way; but some objected to this on account of the bleeding that might ensue, and others on account of the scar or deformity of lip that might result, and the majority seemed favorable to cauterization or electrolysis, rather than cutting. Dr. Hingston asked me how I intended to treat it. I told him that I had thought of excising it, but since hearing the opinions of other surgeons, I had half a mind to use the cautery. He said if it were his case, he would unhesitatingly cut it out, but if I inclined to cauterize it, he would advise the use of Paquelin's thermo-cautery.

As I had just finished the cure of a *nævus*, situated above the eyebrow, on a child a year old by the thermo-cautery, I dreaded the frequent applications that would be necessary, especially in this case, and the scar that would almost unavoidably result from the eschar, and decided at once to excise it. On the 12th inst., assisted by my partner, Dr. Henderson, I removed with a pair of scissors a triangular piece the whole thickness of the lip, including the *nævus*, with the apex at the nostril and the base at the margin of the lip, and brought the edges of the wound together with pins in the usual manner. Bleeding was free but easily controlled by the pins and ligatures, and the healing of the wound has been rapid and perfect, to-day there being only a seam to mark the site of the tumor, and this in a few months will be scarcely perceptible. The interest in this case centres

in the differences of opinion given by eminent surgeons as to the best way of dealing with such an affection, and the satisfactory result which has followed the quickest and certainly the simplest method of getting rid of it.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—I observe a printer's error in my communication of last month in regard to date which I would feel obliged if you would correct. The sentence reads as follows: "In 1822 the students of the Toronto School of Medicine did meet in friendly competition students of another school (Trinity) in the fourth year's examination, with the result that the Toronto School students did not obtain either of the two gold medals." It should read: In 1882 the students, etc.

Yours, etc.,

London, Oct. 20, '83.

PRACTITIONER.

GRATUITOUS MEDICAL SERVICES.

(To the Editor of the CANADA LANCET.)

SIR,—I would like to ask you or some of your numerous readers who have facilities at their disposal to give a description or account of the differences and resemblances in the *gratuitous* medical services, *rendered to those well able to pay*, in connection with our colleges, hospitals and boards of health. Also, how to reconcile such *gratuitous* services with the "Code." It appears to me nothing corresponding obtains in any other than the medical profession, and as far as I am able to judge the medical profession is not only much injured but much lowered in public estimation by the practice.

Yours, etc.,

October, 1883.

M. B.

Reports of Societies.

MICHIGAN STATE BOARD OF HEALTH.

Reported for the CANADA LANCET.

The regular meeting of the State Board of Health was held in Lansing, Oct. 9, 1883, the following members being present: Arthur Hazle-

wood, M.D., of Grand Rapids; C. V. Tyier, M.D., of Bay City; J. H. Kellogg, M.D., of Battle Creek; and Henry B. Baker, M.D., Secretary.

The secretary presented his annual report, showing valuable accessions to the library by gifts and exchanges, also his quarterly report of work done in the office.

The Board was invited to hold a Sanitary Convention in Hillsdale; also to hold it in Ionia. Both invitations were accepted, and it was decided to hold the one in Ionia early in December.

The Board was also requested to translate the documents on the prevention of contagious diseases, in the Scandinavian and Finnish languages for the use of miners and others who do not read English, and among whom both scarlet-fever and diphtheria are now present.

It was decided to hold a meeting of the Board in Detroit, Nov. 13, to attend the meeting of the Public Health Association, and to transact such business as may come before the Board.

A communication from the Chairman of the Ontario Provincial Board of Health gave notice of a Sanitary Convention at London, Ontario Nov. 16 and 17. Drs. Baker and Hazlewood were appointed to attend this convention.

The secretary presented a resumé of the work of other Boards of Health:—

The Boston, Mass., Board of Health has lately placed measles on its list of diseases to be reported to the Board by householders and physicians. That Board has publicly offered to superintend the process of disinfection, if requested to do so by the householder. Dr. Kellogg thought it desirable that Boards of Health superintend disinfection after contagious diseases, where possible. He thought disinfection by sulphur would be more efficacious, if carried on in a moist atmosphere.

Selected Articles.

CLINIC ON SKIN DISEASES.—BULKLEY.

CASE I. PSORIASIS TREATED WITH CHRYSOPHANIC ACID.—This case is very interesting, from the fact that, without our intending it, we have had quite a remarkable improvement in the eruption from a treatment which has been advised, but which has not been frequently employed—namely the internal use of copaiba. The patient came here first

on account of gonorrhœa, and not for his psoriasis, which he had had for twelve years, and was put on the treatment for gonorrhœa—on what is known as the Lafayette mixture—a mixture containing an alkali and a little spirits of nitre. When he first came, on April 12th, the psoriasis was in full bloom, very much more marked than now. He was given the mixture of copaiba, but with no local treatment, and as his gonorrhœa diminished his psoriasis greatly improved, so that now his eruption is not of half or quarter its former extent. He says there are no new spots, and, as you see, the eruption is fading. His name is J. B., aged twenty-four. He has had psoriasis for twelve years, with occasional improvement, followed by relapses or increase of the eruption from time to time, it having never entirely left him since its first appearance. What I show you now is not the eruption of psoriasis as you are apt to see it; it has decidedly faded, some of the spots have disappeared, and many are much broken into. On the elbow you will still find the white, slightly adherent, imbricated scales, which very readily come off with slight scraping; they are seated on a red base, which, as always, is perfectly distinct and sharply defined, and not with the indefinite outline commonly seen in eczematous patches. On scraping off the scales lightly we soon come to a membranous pellicle, which is adherent, and, if the scraping is carried still further, this comes off and is followed by the appearance of a drop of blood. The eruption, as you see consists of dusky-red spots, of a size varying from that of a minute pin-head to almost any size, always sharply defined, tending to cover themselves with a white scale, which, on being scraped off, leaves a red base, which bleeds very readily. Remember that the separate spots of psoriasis always appear first as small points, gradually enlarging, and that even when seen as patches of large diameter they have always thus begun; in some localities you may observe the mode of disappearance of the eruption, it gradually fading out, the scales ceasing to form, and finally the redness itself vanishing. We see on the legs very much less eruption than is usually seen on these parts; as a rule, in psoriasis, the legs have more of the eruption proportionately than the body; almost always the patches are larger on the lower extremity, more scaly, and of a darker hue.

Differential Diagnosis.—Why do we speak so confidently of its being psoriasis, and state that it is absolutely impossible that it could be anything else? The reasons are found in the character of the lesions, taken in conjunction with the history of the duration of the eruption. There are only four eruptions which could with the slightest reason be supposed to be the one before us; these are: A squamous syphilitic eruption, an eczema, a ring-worm, and psoriasis. First, of syphilis: This man has had the eruption for twelve years, with varying

severity, and this eliminates syphilis absolutely, as such a general syphilitic eruption never continues that number of years. You may have an ulcerative syphilide for five or more years, but never an acute, distinct form of this kind. In the next place, the syphilide would be on the flexor and extensor aspects alike, while in psoriasis the extensor surfaces are always the seat of preference. In the general large papular eruption you could never have any such extensive patches of disease as are seen on this man's legs. Second, in regard to any possible form of eczema which might be mistaken for the present eruption. Eczema seldom, if ever, presents so many separate points of eruption as are seen here; and it may be said that it never exhibits so many of such small size and so sharply defined. Upon some portions of the body psoriasis may resemble eczema, and you see the characteristics it very commonly may take on on the lower extremities—namely, the patches are larger, more dusky-red, and of more undefined outline, often more resembling an eczema of the lower extremity. It would be difficult, but not impossible, to make the diagnosis from the eruption on the lip alone. In certain points this eruption might be thought to resemble ringworm, but yet you would certainly not have such a vast expanse affected with the parasitic disease, and an examination of the scales by the microscope would show the parasite in the latter. The individual spots present differences from those of body ring-worm in the pearly character of the scales, the absence of a clearing in the centre, and rather livid redness of the base of the psoriatic spots. We then make the differential diagnosis from syphilis, eczema, psoriasis, and ring-worm; and, recognizing the lesions of psoriasis, we conclude with certainty as to its nature.

This patient continued the use of balsam of copaiba until the eruption was a good deal faded and broken up, and some weeks ago he was put upon another treatment which has recently been advocated. He has been under the internal use of chrysophanic acid, which has been reported on favorably by several observers, some claiming brilliant results from it. I have several patients under this treatment, but can not yet speak definitely concerning it. He began with a quarter of a grain, in a powder with sugar of milk, taken three times a day directly after eating; and a week ago I doubled the doses. It is best always to begin with a quarter of a grain, and after a few days give half a grain, and then a grain, until some effect is produced on the stomach and bowels. Some patients are said to have taken up to four or five grains several times daily. When you get to five grains there is sure to be purging and vomiting. He is under this treatment, and has not had any effect from it as yet; but we shall continue it for some time to come, and I propose to push this treatment in as large a number of cases as possible. I wish to give

you at present time the diagnosis and treatment in these cases as we see them, and the theory of treatment I will give you later in the course.

CASE II. ECZEMA RUBRUM.—I bring you this woman to show you a leg which is scaly. It is a case of eczema rubrum of the left leg. She is forty-three years of age, attends to her own household work, being therefore more or less constantly on her feet, and has an eruption only on this leg. I merely want to show you that, although an eruption is scaly, although it is red, it may not be psoriasis. No case of eczema ever becomes psoriasis. The patient states that she had erysipelas eleven years ago, and that it broke out again two years ago and settled in her back. You will see a great many cases which are called erysipelas, and chronic erysipelas, of the face, etc. We all know there is no chronic erysipelas. It may be chronic by recurrence, but not such an affair as this. This is chronic eczema, which never presents numerous well-defined, sharp patches. See how uneven the edge is, and how it shades off into unhealthy skin; you get a certain amount of erythematous skin, you get it on one half of the body, or, if on the whole body, in continuous patches. This is erythema rubrum, and is one of the cases which, of all others, are perfectly treated with the rubber bandage. I am sorry I can not put it on to-day, to let you see how to do it. I am afraid this patient does not put it on tight enough. If this leg were exposed to the open air it would crust over, and if closed up at night there would be a surface that would exude moisture. Leave it alone and exposed to the air and that moisture tends to dry. If she had left it alone, untreated, and had scratched it, it would have a large crust; if treated with the rubber bandage there would be no crust upon it, but the scales would come off on removal of the bandage. She states that she left off the bandage for over a year, and that the leg was in as good condition as this until August; but in August, from over-fatigue, she had the eruption develop in spite of the bandage. The tongue is quite indented, and considerably cut; her bowels act every day; her water is much colored, and stains the vessel considerably. She is taking some medicine, but I do not know what it is. We expected her to say the water was stained. Most of the cases of eczema of the leg are connected with highly colored urine, with a heavy sediment of lime, or some other deposit, from imperfect elimination by the kidneys. It always recurs from over-fatigue or over-exertion.

Differential Diagnosis.—There is nothing like this disease at all, except psoriasis, and that does not come in such a profuse form.

With regard to *local treatment*, the bandage is the great thing; it is an invaluable addition, and she would hardly know what to do without it. We shall later on have an opportunity to see it put on, and then I will speak of the mode of treatment.

For *internal treatment* you generally give diuretics, a cathartic, and usually some tonic with all.

CASE. III. ECZEMA RUBRUM, WITH VARICOSE VEINS.—Mrs. D. aged fifty-two. She had a milk leg—that is, the left leg was affected twenty-two years ago, and again nine years ago. About December 1, 1880, an ulcer made its appearance on the left leg from which there are large scars, and an eruption shortly appeared after it, and gradually extended up the leg, involving the greater part of the leg when first seen, January 1, 1881. I show you these patients that come back to us, as they are instructive. We get them well to a certain extent; they leave, and there is a relapse. Many of the eruptions have a predisposition to return. She first came to see us January 26, 1881, and was here under treatment for two or three months. She got well under the rubber bandage, then she disappeared, and we did not see her again until September, 1882—a year and a half, which is, of course, a good immunity for a person who is on her feet all the time. The trouble came back in September, and it began on the 22d, four days before she was seen. Here we have the same lesion as in the former case, accompanied with varicose veins, with very considerable varicosities of the feet. We note here an erythematous condition, which disappears entirely on pressure and readily returns on taking away my hand. You notice the œdema of all the parts. Most cases of eczema of the leg are associated with œdema, which is not necessarily owing to kidney causes. In this instance it is secondary to the milk leg, or phlegmasia, she had first twelve years ago, and again nine years afterwards. I think, if we want to have our patients remain cured, we must require them to wear the bandage continually, just as persons with certain deformities of the body require the continual use of a bandage or truss; for as a consequence of leaving off the bandage, we get an affair which seems like a purely local disease. You see some persons with varicose veins who do not have the eruption at all, while others, without having varicose veins, have the eruption. This is, I believe, wholly constitutional. We put her upon the treatment which is commonly prescribed here, and you will hear frequently of it; but I hope you will not consider it routine practice—that is the diuretic treatment. She is taking the acetate of potassium; it relieves the congestion of the skin, and certainly removes the disease. She is now taking thirty grains three times a day, in a little rhubarb-and-soda mixture, which is mainly used. Locally she had applied an ointment of salicylic acid and balsam of Peru. I merely mention that ointment, but can not speak further about it now; it is composed of about half a drachm of salicylic acid and a drachm of balsam of Peru to the ounce.

CASE IV. RECURRENT ECZEMA.—I now show you a case of recurring eczema in a child whom I

showed you last year—a child who, when you saw her then, had an eczema all over the neck. She remained entirely well until this fall. We saw her here last March, with a history that when six months old she had an eruption lasting until eighteen months ago—I am reading the first record of March, 1881—and this eruption had been on the head for twelve months when we saw her. The head was the seat of a squamous eruption, and all the upper part of the neck, back, and chest was likewise affected with eczema rubrum. There is some moisture there now. She is over four years old, and, you see, is an exceedingly small child for her age. When you saw her last year the entire neck was the seat of a moist, exuding eruption. The head was entirely crusted over, and the child was suffering very considerably. There were enlarged glands in the neck, indicating a low vitality and a scrofulous condition. What she shows to-day is a small amount of scaling, which I wish you to look at closely. I want you also to see this eczema of the eyelids in a child, because such patients are taken to oculists and treated with blue-stone for years, while, if treated as eczema, they would get perfectly well. You see here a swelling of the lids which would not be here if it were not for this eczematous spot, and you find the remains of eczema on the lips. That, of course, may vary to any extent; there may be a thickened eyelid, and when you find it in eczematous subjects you can be pretty sure it can not be cured without proper constitutional treatment. There is a slightly reddened condition of the eyelids—a puffiness of the whole region of the Meibomian glands. Now, here we still see a certain amount of redness, and a certain amount of erythematous thickening, as the remains of the eczema. I have not seen her for a long time.

Eczema of the eyelids is treated frequently with stimulating solutions—with nitrate of silver, blue-stone, etc., without effect, until the proper treatment for eczema is used. The erythematous condition of the neck is hardly worth seeing. She is better than she was a year or so ago. It is a little over a year since the child had any treatment at all. The scalp was crusted over and the hair matted down, and there was some eruption on the upper lip and on the arms when she came here, September 20th. She was given the syrup of the iodine of iron, a teaspoonful three times a day, and locally she was to use the ointment which you will see continually used, namely, the tar-and-zinc, two drachms of tar, and six drachms of simple ointment, or rose ointment. That treatment has been continued from the first; she has had nothing but the iodide of iron and the tar-and-zinc ointment. I do not generally use the treatment with the iodide of iron in eczema; that was given in my absence. Although I do not wish to reflect any discredit upon this treatment, yet I do not use it; I do not know why, but I have not been as well satisfied with it as with

other treatment. I shall put the child on a little arsenic and ammonia, or the citrate of iron, or the citrate of potassium and sweet wine of iron, made with Malaga wine, under which, I think, such patients improve faster than under the iodides.

CASE V. GENERAL DIFFUSE PAPULAR SYPHILIDE. —I show you quite a different eruption now, gentlemen, in a case of specific disease. I will say, once for all, that I consider it a good deal better to use the term specific disease, and I only use it for one disease—syphilis. Whenever I use the word specific it refers to that, and that alone; it saves me explanation and uncertainty. It is a case of early general diffuse, or general scattered, papular eruption from syphilis. The patient is a widow. She had one child, who died soon after birth. She has had the present eruption for the past three months. When seen a week ago, all the body, face, hands, neck, arms, and legs were covered with grouped papular syphilide, and she has mucous patches in the mouth. I show you the case, gentlemen, for you to compare with the first case I showed you, the case of psoriasis, which in appearance this resembles to a slight degree. Here is a moist eruption which somewhat resembles psoriasis, but the scales of specific disease are always slight as compared with psoriasis. Specific disease does not tend to cover itself with scales, except in the tubercular form. This is a little dark, a little large, and a little too prominent to be confounded with psoriasis. Here is a very interesting point: you find here what is termed psoriasis palmaris syphilitica. Now, in any case of psoriasis you will find spots like that developed in the palms of the hand. If there is doubt in your mind, *there* is a point which would argue nine out of ten times in favor of its being specific disease. This is a general, large specific papulide. This woman's primary lesion must have attacked her within six months. There is no eruption on the soles of the feet. There is sometimes seen a little circular grouping of the lesions, but it does not happen to occur in this case; when it does occur it is perfectly pathognomonic. Here is the general large papular syphilide that might have been covered with more scales, and might in certain other cases represent psoriasis. Here is a wax model of the lesion; They call it *syphilide palmaire*, but there is no propriety in calling it that. Now, you notice I have made this diagnosis without a word from her. I do not care whether she had the primary lesion or not; there are characteristics which are absolutely positive. You will see the spots are solid, and are erythematous, and disappear on pressure; they are not stains; they may be acute and new, and there are also some stains left from the former lesion. There is some little analgesia, or loss of sensitiveness to pain, during the early acutely developed phases of syphilis. It is more common in women than in men. I have patients on this platform into whom I could stick

a pin without their knowing it. There is entire loss of sensitiveness. We have here a general diffuse papular syphilide on the face, as well as on the body, and I should suspect the face if there were none on the hands. There are features here which might be mistaken for those of acne, and might be something else; but one point would lead us to diagnose syphilis, and that is the scattered appearance which the lesions present—I mean covering the whole face. You see an acne group, but never see an acne on the lip in that way. She is under the “mixed treatment.” I believe in giving her a slight amount of hydrargyrum early in the disease, and I believe occasionally a little iodide added to it will help the disappearance of the eruption. She is taking a mixture with a little iodide in it, because it does hasten it, in my judgment. She has been under the treatment only a week or ten days, and the eruption is getting somewhat less than it was.—*N. Y. Med. Jour.*

THE DOME TROCAR IN OVARIOTOMY, PARACENTESIS, ASPIRATION, ETC.

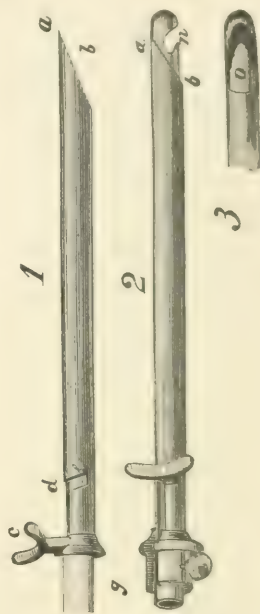
BY S. FITCH, A.M., M.D., EDIN., HALIFAX, N. S.

We reprint the following from the Transactions of the International Medical Congress, in order to bring again to the notice of the profession an ingenious and useful instrument, the value of which is not as well known as it deserves to be. After giving a history of the invention of trocars in general and the improvements in his own instrument, the author proceeds as follows:—

I now announce a most important modification of the double tubular trocar, which avoids the danger of the open canula, and by which the instrument, while performing its highest achievements of discovery and cure, may be used as a trustworthy exploring probe and sound; and which will, I believe, in time supersede every other form of the instrument. Retaining my first improvement of making the outer canula the puncturing, or rather the incising, trocar, I have had the distal orifice, or open top, of the *inner* canula closed over by a rounded or dome-shaped roof, so that, when it is projected beyond the cutting point of the outer canula, the two tubes fit closely together, and the end of the combined instrument feels perfectly smooth like the end of a rectal sound, or catheter, or probe, and may be freely moved within the cavity penetrated, whether this be an ovarian cyst, a uterine fibro-cyst, the abdomen, the thorax, the bladder, a joint, or even the pericardium, without danger of wounding any viscus or organ, puncturing any vessel, or even scratching or abrading

the lining of the cavity, or of any parts contained therein.

The base of this *dome* being of the same external circumference as the inner tube, of which it is the continuation, and fitting the outer tube accurately, there can be no escape of fluid till the dome is advanced or pushed out so as to occlude and shut out the cutting point of the outer tube; then there is disclosed by this movement a fenestra, or oval aperture on the *under side* of the inner tube, just



Figs 1, 2, 3, represent the dome trocar. Fig. 1 shows the cutting point (*a b*) of the outer canula advanced, ready for puncture, with the dome of the inner canula retracted, shutting the instrument just behind the point (*b*) against ingress or egress of fluid; *c* is the thumb-rest for projection and retraction of the dome by the thumb of the hand holding the instrument; *d* is a slot with a knob regulating and fixing the dome and point in any desired position; turning the knob one-half revolution into the proximal transverse slot allows the tubes to be separated for cleansing and oiling. Fig. 2 has the thumb-rest pushed forwards and turned into the distal branch slot, projecting the inner tube and dome, sheathing the cutting edge and point (*a b*) of the outer canula, and disclosing the fenestra (*n*) cut out of the under and side walls of the inner canula; *n*, in Fig. 2, and *o*, in Fig. 3, show the curved process of the lower wall of the inner canula, underlying the proximal third of the fenestra, to prevent occlusion from contact of cyst-wall, or vein-wall, or any floating substance.

below the roof, or dome, cut out of the lower wall and one-third of each side-wall, of the full size of the bore of the tube, and by which fluids may be freely evacuated or injected; the distal end of this segment is sloped off towards the dome, so that no obstruction can lie there, while at the proximal boundary a curved lip projects over one-third of the whole fenestra to prevent the possibility of obstruction; and the fenestra thus guarded, and

being, moreover, on the under side, cannot be stopped by the wall of the cavity coming into contact with it, nor by the falling upon it of any natural textures, or layers of false membrane, or flakes of plasma, as often happens with the open end of the old canula. If, while discharging the fluid for which it was introduced, there be found an aggregation of cysts, or a multilocular sac, this instrument may be used as a long artificial finger to examine the interior of the original cavity, and to feel for a proper place to enter, where it may be held till the cutting point is advanced to make an aperture for its introduction.

Thus, in ovariectomy, it will be found extremely convenient, the left hand supporting the tumor and the right holding the instrument, which can be instantly changed, by an easy movement of the same hand, from a trocar to a sound, and *vice versa*, to define and puncture cyst after cyst, until the bulk of the whole is sufficiently reduced to admit of withdrawal through the abdominal incision, with only one aperture in the cyst-wall first punctured, and this always occupied by the instrument which prevents leakage, and the dome trocar may here be used, where the end of the open canula could not be with safety, to stir up and liquefy the loculose contents and to break down such obstructions to the flow as imperfect septa and membranous intersections, while it still plugs the original aperture, thus preventing escape of cystic fluid into the cavity of the abdomen, and it oftentimes obviates the necessity of enlarging the aperture in the cyst for the introduction of the hand, which procedure should be avoided as involving overflow of cyst-fluid upon the peritoneum.

In operating for hydatids of the liver or kidney, the dome trocar, of aspirator size, may be used to loosen and dis sever these little bodies while the aspirator is extracting them through the same instrument. And we may, with one of these smooth-ended instruments, of suitable length, search for and drain off the last drops of urine, during aspirato-puncture of the bladder, which we dare not do with the end of the open canula, much less with the sharp point of the ordinary single-tube aspirator needle; or, while the dome instrument is within the bladder, we may use it to explore the interior both before and after emptying it. In cases of intractably enlarged prostate, I believe that we may properly reach the bladder by perforating this gland with a dome trocar having a less curve than an ordinary sound, and thus not only relieve the bladder at the time, but give permanent release from the oft-recurring retentions. I have forced a common strong catheter through the prostate in such a case; and the patient, who was previously nearly worn to death with his disability, is now enjoying a new prostatic bit of urethra, and is independent of instruments.

The life-giving operation of *transfusion* may, I

think, be quickly and well done with this instrument. A short dome trocar, of suitable size, having been attached to each end of an India-rubber tube a foot long, with the middle expanded into a bulb, one of the trocars is inserted into the vein which is to furnish the blood, and, when the apparatus is filled, the other trocar is introduced into the receiving vein, when the operation is completed. The tubes are closed and opened at their distal ends by retraction and projection of their domes, which prevents the possible admission of air; and no valve or stopcock is needed. The receiving vein should be exposed by a short incision, but the supplying vein will generally be sufficiently prominent to be entered without previous dissection. As soon as the lancet-end of the outer tube is inserted, the dome is projected, and the tubes thus guarded may be safely pushed as far as required, downward into the furnishing vein, and upward into the receiving vein, and no ligature will be needed. Thus time, so valuable in this operation, is saved, disturbance of the vein is avoided, and injury to the interior of the vein need not be feared. If the *mediate* method be preferred, a common glass, or hard India-rubber, or metal, syringe, with the piston removed, and the nozzle inserted into a flexible tube, armed with one trocar, will be a suitable reservoir into which the blood may be caught, as in ordinary venesection; or the blood may be defibrinated by whipping, and strained into the syringe; the dome with the open fenestra is left projected till the trocar fills, then it is retracted, closing the fenestra, and leaving the point of the outer tube ready for puncture. Upon inserting the trocar, we need not replace the piston, for sufficient and more steady propulsion may be obtained by merely raising the syringe. The hole in the side of the nozzle, used by Mr. Wagstaffe, is liable to occlusion from the contiguous wall of the vein; in the dome trocar this is obviated by a curved projection of the tube-wall over the proximal end of the fenestra, open at the sides, as previously described. In this operation it is very important that the dome be solid to prevent lodgment of clot.

The *aspirator attachment* deserves attention, for it can be applied to any syringe or exhausting apparatus; the adjustment is effected instantaneously and without moving either trocar or exhausting apparatus, or twisting the flexible, connecting tube, by merely pushing the end of the aspirator nozzle into the funnel-shaped end of the inner canula, and fixing it by one turn of a loose ring-nut, like a hose-coupling. The India-rubber tube connecting the nozzle with the aspirator has the usual bit of glass-tubing, so that the current may be observed or its absence noticed.

Some peculiarities of the different sized instruments should be mentioned. The *ovarian trocar* has a thumb-nut (for which I have to thank Dr.

Thomas Keith), by which either the cutting point or the dome may be advanced or retracted, and fixed in either position by the thumb of the hand holding the instrument. The proximal end of the inner canula is prolonged into a hollow, curved handle, very convenient to hold by, while it also directs the current of the flowing liquid downwards; and one end of an India-rubber tube, three feet long (with a bit of glass tubing in it), may be drawn over the lower orifice of this hollow handle, to conduct the fluid into a receiving vessel; the middle of this tube is expanded into an elastic bulb, by which the flow through the tube may be promoted until the syphon current is established; and we may use it for washing out or for injecting the cavity. Mr. Wells' grapples may be slipped upon this trocar, or long, light clamp-forceps, with ring-ends, may be used to seize the sac, upon or even before puncturing, and, held in the hand with the trocar, will accommodate themselves to the varying distances to which the trocar enters.

The *trocar for paracentesis abdominis* has a curved, hollow handle continuous with the inner tube like the ovarian trocar. All the sizes below that for paracentesis abdominis, have their proximal ends adapted to the aspirator nozzle, and therefore a separate, curved, hollow handle is provided to fit all of them, and may be instantly fixed to either by a ring nut, similar to that of the aspirator nozzle; and with this handle an India-rubber tube and bulb may be used, as with the ovarian trocar, when we wish to simply empty a cavity without the aspirator. The instruments may be of any size. Of those which I have had made, the *ovarian trocar* is ten inches long, including the handle which is four inches, with the internal diameter of the inner tube half an inch. Dr. Washington L. Atlee tells me that he has used one of these in his last forty-one ovariectomies, and expresses unqualified approval of it.

The *abdominal trocar* is six inches long, including two inches for the handle, the calibre equalling that of a No. 11 catheter of the American scale, 17 of the French. The *smallest sizes* correspond with Dieulafoy's aspirator needles; of these, two are each seven inches long, and fine, for the bladder and deep tapping; two are four inches in length, and stouter, for hydrothorax, transfusion, etc.; one is short and very fine, for hydro-pericardium, spina bifida, etc.

The same principle has also been applied in the construction of a dome trocar catheter, by Dr. Fitch, for tunneling the enlarged prostate, for supra-pubic or rectal puncture of the bladder, and for tapping ovarian cysts *per vaginam*. This instrument is virtually a catheter within a perforating tube. The main object intended is to make a direct channel through the enlarged prostate, instead of nibbling off fragments of the gland through the floor of the urethra, as is attempted by several

recent contrivances. It will likewise be found most efficient for puncture of the bladder from the rectum, for discharging noxious intra-peritoneal effusions, for antiseptic washing of the peritoneal cavity through the retro-uterine cul-de-sac, and for evacuating and injecting ovarian cysts *per vaginam*; and it will be of immense value in supra-pubic lithotomy by opening the bladder from within, outwardly.

JENSEN'S CRYSTAL PEPSIN.

The following extracts are from an article by Hugo Engel, A.M., M.D., in a recent number of the *Medical Times*, Phila.

Of the many new preparations which have recently appeared in the market, there are comparatively so few possessing real value that when we meet with such of the latter class we should not withhold just praise and make their merits known to the profession.

Mrs. M. had been nursing her youngest child, a boy, until he was seven weeks old, when her right breast inflamed. Her physician forbade her nursing the infant with the sound breast, in consequence of which the secretion of milk soon ceased totally,—a result which proved injurious alike to mother and child. The child, after being weaned, emaciated rapidly, so much so that when it came, some two weeks later, under my charge, it already suffered from that condition called marasmus. I regulated the feeding of the infant with diluted cow's milk, to which some sugar and a grain of salt were added. The nursing-bottle was kept scrupulously clean, the temperature of the milk uniform, and the feeding done regularly every two hours. After four days the discharges from the bowels still continuing unhealthy and the child losing flesh and declining in general health, pepsinum saccharatum in the dose of five grains was added to the milk. For the next day or two the child seemed better; but when it relapsed into its former condition, first the same dose of Scheffer's and then of Boudault's pepsin, to either of which diluted hydrochloric acid was added, were substituted for the saccharated pepsin, with, however, the same want of success. I then ordered, for the first time in my practice, Jensen's pepsin, gr. ii, with one minim of diluted muriatic acid, to be administered four times daily when the child was fed. Immediately, almost, an improvement began, and the boy grew strong and plump during the following seven or eight weeks. The parents now moved to another part of the city, and as it seemed very inconvenient to have the medicine put up by the apothecary in their former neighborhood, they asked him for a copy of the prescription, and brought it to a drug-shop not far from their new residence. It had taken the medicine prepared at the new place for about five or six days,

when again it was brought to me with every sign of relapsing into its former marasmic condition. I advised the mother to procure the solution once more from their former apothecary. This was done, and again improvement began almost immediately. Some three weeks later, a part of the medicine having been spilled, and the latter suddenly giving out, the parents were again induced to buy the pepsin in the neighborhood, when it became apparent to even the most superficial observer that the benefit the child had derived was due to Jensen's pepsin: again the boy's health declined, and he lost flesh; and when the now frightened and thoroughly convinced mother again substituted the old preparation, she once more had the pleasure of seeing her infant thrive.* No further disturbance in the health of the latter took place; the baby looked the picture of health, and when with the appearance of a sufficient number of teeth the child was able to digest a more solid food, the dose of the medicine was gradually reduced in size, until at last the boy continued to do well without the assistance of artificial gastric juice.

Mrs. R. requested me to attend her sixteen-months-old child, suffering from cholera infantum. After I had succeeded, by baths, by the utmost attention to cleanliness, and by insisting upon the little patient being carried about in the fresh air during the cooler hours of the hot summer days (it being July), and by permitting it to make frequent trips in the ferry-boats and steamers proceeding up and down the Delaware, and by appropriate medicine, in putting a stop to the vomiting and the frequent morbid discharges, I administered pepsin in conjunction with dilute muriatic acid to improve the digestion. But the result was by no means satisfactory until I prescribed Jensen's pepsin, when within a few days a decided improvement was noticed; and, as this continued steadily, I discharged the child as well. About a week later it was again brought to me, on account of a relapse. I then elicited the following. As long as the mother had to come with the child to my office, she had the medicine put up by an apothecary to whom I had sent her; but when the visits to me were discontinued, she considered it too great a distance to send for the medicine, and so she procured it from an apothecary in her neighborhood,—with what effect has been mentioned. I told her what I thought, that perhaps the medicine did not contain the genuine preparation I had ordered, gave her a new prescription, and advised her to have it put up by the former apothecary. She did so, and the immediate improvement of the baby was too apparent not to ascribe it to the medicine.

Besides these two cases, I will mention, with as

few words as possible, two more. One was that of a lady *enceinte*: she was suffering a good deal from nausea and vomiting. Other remedies having been tried, but without success, I prescribed pepsin,—at first, however, with no result at all. I then changed it to Jensen's pepsin, and after the third or fourth dose the disagreeable symptoms had ceased almost. When I discharged her she asked me if she could have the medicine prepared by a relative of hers, as she would get it much cheaper. I consented, but cautioned her to let me know immediately when her former symptoms should return. Her relative evidently substituted a different preparation of pepsin, as the lady, after having taken his medicine for a day or two, returned to me with the information that the nausea had again reappeared, though not as yet the vomiting. At my advice, she procured the pepsin from the former apothecary again. The result was as expected: the nausea ceased again.

The last case which I pick out from a large number was that of a girl, *æt.* 16, suffering from chlorosis. No matter which preparation of iron I tried, her stomach would rebel: either vomiting or severe nausea would set in, or she would feel a heavy pressure in the epigastric region. I then prescribed Jensen's pepsin with dilute hydrochloric acid to be taken at the commencement of each meal, and the iron about half an hour after the latter. From this time on she was able to take the iron. She also (this being the reason I mention her case) procured the medicine with the pepsin once from an unreliable apothecary, and with the same result as attended the other cases reported: the symptoms of indigestion returned, to disappear again on the resumption of the genuine preparation. I had frequently tried every imaginable combination to prevent the disturbance of the stomach happening in some persons whenever they have to take opium or any of its preparations. I could report a long series of cases in which the annoying symptoms ceased on combining Jensen's pepsin with the opiate; but those mentioned above will be sufficient to prove from actual experience that we possess in this remedy a preparation of pepsin superior in every respect to all others of its kind in the market.

The following will be of interest regarding pepsin preparations in general and Jensen's in particular. Pepsin itself is a ferment. There has as yet been no method detected by which it would be possible to obtain pure pepsin. Every process by which pepsin is manufactured, no matter if by simple digestion and evaporation (primitive, Lamatsch's), or by precipitation with acetate of lead (French, Boudault's), or by precipitation with a concentrated solution of chloride of sodium (American, Scheffer's), results in the obtaining of only a very small percentage of pepsin, and this of very limited strength. It was thought that especially

* The apothecary in their new neighborhood confessed, later, the substitution by him of Scheffer's pepsin for Jensen's.

by the latter method pure pepsin would be precipitated; but such is not the case. The French pepsin is expected to dissolve twelve times its weight of albumen, Scheffer's and the German, about fifty times. A plain arithmetical example gives us the following figures. One ounce of beef contains four hundred and eighty grains: according to the French Codex, forty grains of pepsin, and according to our Pharmacopœia, ten grains, would be necessary to digest this quantity of beef. But, as a healthy person, besides other albuminous aliments, will eat for a meal a quarter of a pound of beefsteak at least, one hundred and sixty grains of the former and forty grains of the latter preparation would be needed for its digestion. How does this coincide with our usual dose of Boudault's or Scheffer's pepsin,—ten grains?

Jensen's crystal pepsin, which has received the name of crystal (not crystallized, as it is often erroneously called) simply from its peculiar glistening, crystal-like appearance, is (without the addition of an acid) perfectly soluble in water, and not precipitated by common salt, therefore a peptone with very great pepsin-effect; "it has proven itself to be the most powerful preparation of pepsin the market offers, one which is capable of dissolving over five hundred times its weight of hard-boiled albumen." Of its manufacture which seems to be thoroughly known only by Jensen, we can presume that it is prepared by maceration of the stomach and its mucous membrane in acidulated water at a temperature of 38° to 40°; the albuminoids are changed into peptones (causing in this way the production and gain of all latent pepsin), and by a peculiar process the syrup-like mass resulting is dried on glass, when the "pepsin" appears in the shape of transparent scales. So carefully is the whole process conducted, and so utterly at variance with all previous methods, that the property belonging to all other preparations of pepsin, of containing chlorides, is totally wanting in Jensen's. If to a solution of any other pepsin nitrate of silver be added, chloride of silver will immediately appear as a thick white deposit, while the same test applied to Jensen's pepsin will either be without any result or (due to a trace of muriatic acid) a faint white cloud will show itself. When we reflect upon the large quantity of pepsin Jensen is able to get from a macerated stomach, the absence of chlorine in his preparation, and certain well-known physiological effects of muriatic acid on digestion, the following theory does not seem to be so very absurd to the writer of these lines.

In consequence of the great popularity Jensen's pepsin naturally enjoys on account of its reliable and powerful effect and its uniform strength, many imitations have been placed on the market, and are dispensed as Jensen's pepsin. The fact just mentioned (the absence of chlorine), its perfectly dry, crystal-like appearance, and its total solubility

in water without the addition of an acid, will serve to distinguish the genuine Jensen's pepsin from all imitations. It has been thoroughly tested by Dr. Tscheppé, of New York, Dr. Wolf, of Philadelphia, and many other competent and impartial chemists, and found to possess the power of dissolving more than five hundred times its weight of hard-boiled albumen. It is therefore ten times stronger than any other preparation. This fact has an important bearing not only on the size of the dose, but also on its cost: the ounce of this pepsin being sold for one dollar and seventy cents, a dose of ten grains would cost only three cents, and, as one grain of it is equivalent to ten grains of the American pepsin, its great cheapness becomes at once apparent. When testing any preparation of pepsin for its strength, the albumen should be finely subdivided, the solution acidulated with 0.5 per cent. of the pure concentrated hydrochloric acid, and the whole kept at a temperature of about 103°, which experience has proved to be the most favorable for the effect of this ferment.

Pepsin alone has very little influence on digestion: its effect increases with the quantity of acid added. Double the dose of pepsin alone will not visibly accelerate the digestion induced by a single dose; but doubling the quantity of the acid (certainly within the physiological limits) will cause the digestion to be finished in less than half the time. As a rule, the most favorable effect of Jensen's pepsin can be obtained when to each grain of the latter about one minim of the diluted hydrochloric acid is added, but with the proviso that on account of its being a ferment the pepsin is to be first dissolved in water, and to it in its diluted state the dose indicated of the acid is added, as follows:

R.—Pepsin. crystal. Jensen, gr. lxxii;
Aquæ floris aurant.,
Glycerin.,
Syrup. limonis, aa fʒi;

Cui adde:

Acidî hydrochlor. dilut., fʒiss.—M.

S.—Dose: one teaspoonful in four ounces of water to be taken at meals.

No alkali should ever be administered at the same time or in combination with any preparation of pepsin, the slightest addition of such making the latter inert. Of all the acids, muriatic acid is the most favorable in its effect; then come, in the order named, phosphoric, nitric, and sulphuric acids; the vegetable acids having no appreciable effect.

WHAT CONSTITUTES A QUACK.—This question, it is expected, will shortly be answered in a court of law. *The Medical Age*, in commenting on the above, says:—"A member of a firm of peripatetic advertising physicians, of large promises, in the

Dominion, has brought an action, fixing damages at \$10,000, against two prominent physicians who have called him a quack. The Canada Medical Act requires that a physician shall not only be a graduate of a medical college in good standing, but that he shall also pass an examination before the licensing body, who shall be independent of the teaching bodies. This law secures practitioners possessing a much higher average of education than obtains among the physicians in countries not having this salutary law, and the fact of a man's being allowed to practice in Canada is guarantee that he is not what Webster defines as a quack, viz., "a boastful pretender to medical skill; an empiric; an ignorant practitioner." This is the meaning of the word "quack" among the laity, but in the profession a man may have all knowledge of medicine and yet be a quack; and his knowledge may be of very mediocre order, and yet his standing may be good. The outcome of the suit mentioned will be awaited with interest. Will the court decide that "quack" means what the laity hold it to mean, or will it allow the profession to define its meaning? In the former case the verdict must be in favor of the plaintiff; in the latter for the defendants, who unquestionably intended the term to apply not so much to the skill of the plaintiff as to his methods of doing business, his advertising, unwarranted promises of curing, exaggeration of minor ailments for sinister purposes, ostentatious parade of qualifications, depreciation of the ability of brother practitioners, and the various other unethical and immoral devices of the itinerant physician."

ADMINISTRATION OF SANTONIN.—Dr. L. Lewin recommends, in the *Berl. klin. Wochenschrift*, the following forms of administering santonin:

1. R.—Santonini 0.2 gm. = 3 grs.
Ol. cocos nuciferae 60.0 " 2 fl. oz.
Dose: a tablespoonful two or three times daily.
2. R.—Santonini 0.2 gm. = 3 grs.
Ol. amygdalæ expressi. 60.0 " 2 fl. oz.
Ol. cinæ (Levant worm-seed) gtt. 4 gtt. 4.
Dose: a tablespoonful two or three times daily.
3. R.—Santonini 0.2 gm. = 3 grs.
Ol. ricini 20.0 " $\frac{3}{4}$ fl. oz.
Ol. cinæ gtt. 4 gtt. 4.
Dose: a teaspoonful two or three times daily.
4. R.—Santonini 0.2 gm. = 3 grs.
Ol. ricini 20.0 " $\frac{3}{4}$ fl. oz.
Ol. cinæ gtt. 4 gtt. 4.
Sacchari q. s. q. s.
Make into a soft paste with sugar. To be given in doses, during 48 hours.
5. R.—Santonini 0.05 gm. = $\frac{3}{4}$ gr.
Ol. ricini 5.0 " 75 grs.
Ol. cinæ gtt. 1 gtt. 1.
Fill into four capsules.
Dose: one capsule two or three times a day.

Lewin finds fault with all the usual methods of administering santonin. According to him, it should be given in its least soluble form, *i. e.*, in that form in which it will be the least readily absorbed, as the effect desired is not a general, but a local one. An oily solution of santonin undergoes, according to his experiments performed on animals, not the slightest absorption in the stomach, so that under no circumstances is any trace found in the urine. Almost any kind of oil may be employed—cocoa-nut oil, olive oil, cod-liver oil, or castor oil. He recommends that three grains of santonin be mixed with two ounces of oil, and given in four doses. He thinks that a useful addition to the above would be that of an oil contained in santonica, the oleum cinæ æthereum, for the reason that all ethereal oils have been shown to act as poisons on the lower forms of animal life.

TREATMENT OF CHOREA.—In the course of a clinical lecture on chorea, Professor H. Nothnagel remarked that when the disease followed articular rheumatism, salicylate of soda was given; but this treatment had to be pursued empirically and carefully, as nothing was yet known of the nature of the disease. (*The Medical Press*.) Opiates had no effect, neither had calabar bean. Now-a-days potassic bromide was almost always given, but without any good result. As calmatives, and for the purpose of procuring sleep, morphia and chloral might be given. He had convinced himself by numerous experiments that propylamine was useless. Arsenic, in the form of Fowler's solution, was still the most effective remedy. It could be given by itself or in water. He suggested the following:

R Liq. Fowleri, gm. v;
Aq. destill., gm. xv. M.

Five drops to be given in a tumbler of water immediately after meals, and the dose to be increased by three drops every day until it reached thirty drops, after which it was to be slowly diminished. The constant current was another effective remedy in chorea, combined with tepid bathing or the application of ice-bags to the spine.—*Lou. Med. News*.

THE THIRD ELEMENT OF THE BLOOD.—Hayem has repeated his convictions on the subject of the newest phases of the histology of the blood before the Acadèmes des Sciences. As it will tend to make clear some of the confusion which has grown around the question, we give in a few words Hayem's conclusions. We do this the more especially because our readers may compare them with the papers by Norris, lately published in our columns. The hematoblast of Hayem is regarded as the precursor of the red-blood disc and as the agent concerned in the coagulation of the blood.

The "blood plate" or "plaque," described by Bizzozero, is considered by the French observer to be identical with the hematoblast. It will be remembered that Norris has postulated the identity of his invisible corpuscle with Bizzozero's "plaque." By Hayem the invisible corpuscle is still looked upon as a red disc from which the hemoglobin has passed away. Each observer claims for his element an important rôle in the development and coagulation of the blood. Schmidt, of Dorpat, has assigned the chief agency in the process of coagulation of the blood to the leucocytes or white-blood corpuscles.—*Lancet*.

INHALATION OF IODOFORM IN PHTHISIS.—The general practitioner will be glad to make the acquaintance of any device to afford relief to consumptive cases. We have seen some very intelligent patients who persistently maintained that they obtained marked relief from the inhalation of the peroxide of hydrogen. De Renzi and Rummo (*Gazz. Medica Ital.*) claim good results in phthisis and other diseases of the respiratory organs from inhalations of iodoform dissolved in turpentine. The patients were made to inhale twice a day, for two hours, in a small room, the spray of iodoform and turpentine. The effects were more satisfactory than with any other mode of treatment. There was always prompt and considerable diminution of cough and expectoration; in bronchiectasis the fetid expectoration was completely deodorized. Physical signs diminish, the temperature falls, pulse and respiration are less frequent. The secretion of urea is lessened in proportion to the fall of temperature. Iodoform given by inhalation is much more prompt in action than when taken by the stomach; it is an anæsthetic to the pulmonary vagus, and has an alterative and drying local action, which is aided by turpentine. Its antiseptic action must also be taken into account.—*Med. Review*.

PROLONGED GESTATION.—Dr. E. M. Reid relates the case of a patient who bore a child after a gestation lasting two hundred and ninety-five days, at least. *Circumstances were such that the parents were separated during that period previous to the birth of the child.* Dr. Reid is of the opinion that the prolongation of the gestation was produced by the fact that in its course the patient had several copious hemorrhages, viz., on the 177th, 183rd, 189th, and on the 213th day another very profuse hemorrhage took place.—*Brit. Med. Jour.*

[The italics in the above are ours. Dr. Daniel Drake, when Professor of Theory and Practice in the University of Louisville, used to tell the students of a striking example of the power of habit. A woman of his acquaintance in Ohio had for a long time borne a child to her husband every year. She continued this habit for two years after her

husband's death. This might be called an instance of parturient cachexia].—*Louisville Med. News*.

THE PROFESSION'S GREATEST NEED.—In the *N. Y. Medical Record* (July 21) is the following:—"If we were to ask the average practitioner in city or country what was the greatest single obstacle to his progress, he would doubtless say, a field too much occupied. It is the constant appearance of new men, young, eager, and hopeful, which cuts off here and there the extension of his practice, and which threatens to narrow down that which he already possesses. Protection against a horde of superfluous rivals is what the general practitioner, who is himself well equipped and competent, most needs. How can he secure this protection? There is but one way which is at all practicable, and that is by elevating the barriers, so-called, which now mark the entrance to the medical profession." A four years' course and an Examining Board is urged for.

FOR AMENORRHOEA.—Dr. H. C. Wood says the following formula, known as *Dewees' Emmenagogue Mixture*, he relies upon almost exclusively in the treatment of simple atonic amenorrhœa. The amount of iron should be as the anæmia, aloes as the state of the bowels, and cantharides as the susceptibility of the urinary organs.

R Tincturæ ferri chloridi.....f ʒiij
Tincturæ cantharidis.....f ʒj
Tincturæ aloes.....f ʒj
Tincturæ guaiaci ammoniatæ.....f ʒiiss
Syrupi.....q. s. ad. f ʒvj

S. Tablespoonful three times a day. *Columbus Med. Journal*.

TO CLEAN CATHETERS.—A correspondent of the *Lancet* suggests the following method of cleaning catheters: Take a cork of a more conical form than those commonly used, with a hole made through it longitudinally; pass the catheter through the hole, and fix the cork into the tap of an ordinary water-pipe (hot water one preferable), and turn on the water. By so doing the force of the water is greatly increased, and the catheter properly cleaned.

GRINDELIA ROBUSTA FOR ASTHMA.—Dr. Bombelon recommends the smoking of cigarettes, the tobacco of which has been saturated with the resin of grindelia robusta, to asthma patients, whether they are smokers or not. The tobacco must also be well impregnated with saltpetre, which will facilitate its combustion and the development of smoke. If the patient is unable to smoke, the fumes are blown towards him.—*The Med. Record*.

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TREATMENT OF DIPHTHERIA.

In no disease is the range of treatment wider or more varied than in diphtheria. This condition always obtains under a state of uncertainty as to the desired ends, and the best means of reaching them. There could be no better proof of such uncertainty as regards diphtheria, than the numerous remedies, often of an opposite nature, proposed, both for local and internal use. Much of this confusion takes its origin in mistaken ideas as to the real nature of the disease. There are still those who believe that in certain cases at least, diphtheria may be purely local in its operations. The recently published results of an inquiry instituted in Michigan, show that this opinion still prevails to some extent. The prominent part which the local affection plays, and the distress to which it often gives rise, have also greatly tended to draw attention from the systemic nature of the disease, and unduly magnify the local lesions. The consequence is that we have an elaborate, though an ill-defined system of local treatment, involving much trouble and danger to the attendants, and much annoyance, and even great distress, to the patients, especially young children, who are usually frightened beyond measure at the sight of the brush or swab, and summon forth all the physical power remaining to them to thwart the designs of their tormentors. The flow of blood which so often follows this operation, and the accompanying struggles, afford evidence sufficient to condemn the practice. Such treatment is as

irrational as it is barbarous, and nothing but evil is to be expected from it.

The accepted theory of the day is, that the symptoms and lesions which we call diphtheria are always due to the operations of a subtle poison circulating in the blood, the real nature of which is unknown; in these respects resembling the poison of small-pox, and the infectious exanthemata in general. In all these diseases it would appear that the poison has a propensity for working its way from the centre to the periphery—from the blood-stream to the oxygen-bathed exterior. The diphtheritic poison chooses by preference the respiratory tract, changing the mucous membrane into necrosed tissue. It also in a special manner affects the heart-force, and tends to death from cardiac exhaustion. The microscope reveals blood deterioration, and the test tube exhibits albumen. In view of these facts, the pulse and the blood should have our first care. A mild purgative should usually begin all treatment, and should be repeated from time to time if constipation be present, or no tendency to diarrhoea exist. Very often at the onset the pulse is strong and full, and the temperature high. In such a case nothing could possibly be more desirable than pilocarpine, or in its absence, the fluid extract of jaborandi. In the earlier stage of the malady, and while the local disease is yet in the formative stage of the so-called membrane, with its deeper vessels in a condition of intense hyperæmia, the diaphoresis, and especially the ptyalism, which follow the administration of this remedy, can scarcely fail to exercise a beneficial influence. But as this is a powerful heart depressor, it must be given only in suitable cases. Under no consideration should it be given in weakened pulse and failing heart force. We are without proof as to the power of tincture of iron over the blood corpuscles in this disease, but theory would seem to demand its administration. In all exhausting diseases rapid in their progress, quinine is called for, and in none more so than in diphtheria. It should be given as soon as the pulse begins to fail, if not before, and the dose should be proportionate to the exhaustion. As a cardiac stimulant, belladonna holds a high place, and should be combined with the quinine in cases of failing heart action. Alcohol should be given freely as soon as the vital forces show signs of wavering. The quantity usually given is too

small to do any good. In a severe case, it is almost impossible to induce the toxical effects of alcohol. Therefore when it is called for in this disease it should be given more freely than is the rule in other diseases.

The local treatment should never be of an irritating kind. All gargles, washes, and solutions for steaming or atomization, should be of a soothing and agreeable nature, more especially in the case of children. For very young children, the application intended for the throat should be of a nature suitable for internal use, as for example sulphurous acid and glycerine, tincture of iron and chlorate of potash. Independently altogether of any supposed specific action on the diseased surfaces, disinfecting applications must always hold a prominent place, both for the good of the patient and the protection of the attendants, and should be frequently repeated. Soothing and emollient applications to the buccal surfaces, gums and tongue are very grateful. Great care should be exercised in touching raw and painful parts. But as the whole respiratory tract is not to be reached in this way, it is absolutely necessary to resort to inhalation, or atomization, or both. It is claimed by good authority that the local manifestations are checked, and sometimes terminated, by the following: Slake a piece of lime with a weak solution of belladonna; when this process is completed the surplus fluid is decanted, and a quantity of oil of turpentine is incorporated with the slaked lime. The fluid previously drawn off is now added by trituration, after which the whole is strained or filtered. The result is terebinthinated lime water containing belladonna. This may be used at short intervals, or continuously, almost, in severe cases, by two methods, steaming and atomization, steaming being the most efficacious. This is accomplished by placing some kind of frame over the head of the bed and covering it with a blanket, a vessel containing the fluid being kept hot by hot pieces of iron or brick.

The skin should not be overlooked, as it is a great eliminator of systemic poison. It should be sponged with a weak solution of soda several times in the twenty-four hours, and rubbed thoroughly with a coarse towel. The kidneys are also important depurators, and should receive some assistance in the discharge of their function, although it is more the custom to ignore them entirely in

the treatment of diphtheria. But the most important part of the treatment of diphtheria is the diet. Suitable diet is important in all cases of disease, but more especially is this true where blood deterioration and general exhaustion are pre-eminent features. The diet should be of the most digestible and concentrated kind, and should be given as often, and in such quantities, as the stomach will bear. It is important to remember that digestion may be disturbed by injudicious medication. Food is more important than medicine of doubtful benefit. In addition to the more common articles of food, we might mention beef peptonoids. Suspended in broth, they are easily taken, and are very digestible and nutritious.

From amidst much that is heterogenous and bewildering, we have thus endeavored to outline a plan of treatment which we feel convinced is supported by reason, science, and the best experience of our day, and with modifications adapted to each case, will afford the best promise of a favorable issue.

MEDICAL COLLEGE OPENINGS.

The opening of the various medical schools in Canada for the present winter session is an event of considerable interest, not only to teachers and students, but also to the profession and the public. In point of numbers, the attendance at the various schools, the present session bids fair to outnumber that of any previous year in the history of Canada. Abernethy might well say, if he were in the flesh to-day, "God bless you, gentlemen, what is to become of you all?"

The introductory lecture in the Toronto School of Medicine was delivered by Dr. Richardson. After welcoming the students to the school, he alluded to the difficulties attending the study and practice of medicine when he first entered the profession more than forty years ago. He spoke of the progress made by the schools in the city, and expressed regret that a medical staff had not been connected with Toronto University. He maintained that a physiological laboratory should be established in University College, and an eminent professor appointed to teach this important branch of science. He then referred to the great progress in medicine, surgery, and hygiene in his time. The most important doctrines of hygiene

had been developed since the year 1854. It was after the Crimean war that the attention of the government was more especially drawn to the subject, and the result had been shown by the decided amelioration which had taken place in the British troops. The subject he wished to present to them was, whether as members of the medical profession they had any reason to believe that they could find in Nature remedies suited to the diseases they were about to treat; and whether what they found and used successfully in a great many cases were really intended for the purposes for which they were used? In this connection he took up the question of evolution. It was interpreted in different ways by different persons; it did not always mean the same thing. He then proceeded to discuss the position of the ultra school of evolutionists, whose views he declined to accept. He believed that all those things which they could utilize in their profession were pre-ordained, and if this principle were accepted, it followed that they would be able to find as they investigated the matter closely that there was something capable of relieving nature and changing the action of the different parts of the system under their control. In concluding he offered a few words of friendly advice to the students, and asked them to conduct themselves as men and christians. He thought medical students were more sinned against than sinning, and especially asked them not to prosecute their admirable talents for singing which were prone to irritate the feelings of delicate policemen. They were very susceptible, and it must be recollected that they were the guardians of the law. He trusted that the students would prosecute their studies diligently and become a credit to the school.

The opening lecture in Trinity Medical College was delivered by Prof. Sheard, and was a most able and eloquent discourse. After welcoming the students to the college, he said they had no doubt considered well the path they had taken, its difficulties, as well as its attractions, its responsibilities as well as its rewards, its opportunities for good, and its possibilities of evil. He was aware of the tendency of the present time to lead the more promising youth into commercial life. Many were wont to believe that commerce was the golden girdle of the world, binding nations together by common interests and common aims,

but science bound men and nations together by a girdle, the links of which were far stronger, more durable, and more precious than were those of the golden girdle of commerce. Discoveries in the application of other practical sciences were often stayed from their widest spread for the pecuniary gain of the discoverer, but the discoveries in scientific and practical medicine were free to all the world. All medical discoveries were common property, and the richest reward the discoverer could have was the consciousness that lives had been saved, sufferings alleviated, or disease prevented. He then went on to speak of the importance of the study of biology, anatomy, histology, and physiology. Scientific principles were to the physician and surgeon what the compass and sextant are to the navigator. He did not want to separate the science from the art of medicine, for with Prof. Huxley he would say, science and art were the obverse and reverse of nature's medal. But in the qualifications of a trusted medical adviser there was wanting more than fine science, though that must necessarily be the basis. He should have tact, judgment, firmness in opinion, courtesy and gentleness in expression. He did not wish to deter anyone from the laudable pursuit of studying for the medical profession, for a physician's calling was one of the most honourable, ennobling, humanizing, and useful in the world; but he would be partial if he did not warn them to prepare for its criticisms as well as its trials. He then gave a few humorous instances of the criticisms to which a doctor is subjected, and stated that the absolutely gratuitous assistance given by the medical profession to those unable to pay for it far exceeded that which was bestowed or demanded in any other line of life, and it was not less creditable because custom had in a great measure caused it to be expected as a matter of course. If any were adopting medicine because it was an easy life, he advised them either to dispel that illusion or to return home, for without earnest, diligent, and careful application they need hope for nothing. On the other hand, those who were resolute and determined would find in medicine as promising a field as in any other. He claimed that their profession, in the pursuit and use of truth, offered the most complete and constant union of those three qualities which had the greatest charm for pure and active minds, novelty,

utility and charity. Summing up in one sentence what he had been enforcing, he said the secret of all noble life was in belief, and the characteristic of all noble minds in the vigor with which they believed that which was true. Prize strength, love the beautiful, practice self denial, and be patient. Let them resolve to elevate themselves to the promotion of the whole science, art, and charity of medicine. Let that resolve be to them as a vow of brotherhood, and may God help them in their work.

The opening of McGill Medical College this session was inaugurated by an introductory lecture by Dr. Joseph Workman, of Toronto, one of the oldest graduates of the institution. His lecture, which is published in full in the *Canada Medical and Surgical Journal*, was in his usual happy vein. It will also be of value in connection with the early history of the school. In the first part of his address he alluded in fitting terms to the founders of the school. The students of the present day next came in for a share of his attention, in which he cautioned them, while in pursuit of the practical, not to forget or overlook their scientific and classical studies. "Show me," said he, "a man who is fond of botany, zoology, or geology, and I will feel assured he will never be an idler." He also referred to the rich literary treasures to be found in a study of the Romance languages. He then alluded to the munificent donations and bequests which have been given by the wealthy people of Montreal to their Universities, and deplored the fact that ours in Toronto have fallen heir to nothing from the dead and very little from the living. In conclusion, he referred in fitting terms to the memory of departed friends and fellow-students of McGill College, some of whom had left behind them noble records of good deeds.

The Montreal School of Medicine, emerging from the trials of the past summer, opened with more than usual joy and eclat. The president, Dr. D'Orsennens, gave the introductory lecture, in which he alluded in stirring terms to the difficulties through which the school had so successfully passed, and paid a glowing and enthusiastic tribute of respect and thankfulness to the Sovereign Pontiff, who so kindly listened to their cry of distress, and replied in a manner so prompt and paternal. Moreover, the sending from Rome of an apostolic delegate to Canada was, for the school, a sure guar-

antee of a still more perfect re-establishment, and the proof that it will be forever now, even in the eyes of ecclesiastical authority, established on a solid and immovable basis.

In Bishop's College and Laval Medical School no special introductory lectures were given this year, but the classes re-assembled as usual on the opening day. In the Western University Medical School, London, the session was opened by an able and instructive lecture by Dr. Bucke, of the London Asylum. The lecturer alluded in hopeful terms of the prospects of this comparatively new school. From the Kingston Medical School the only report we have is of the opening of the Women's Medical College, the introductory of which was delivered by Dr. Lavell. This school has been established on a good financial basis, and the attendance of students is encouraging to the faculty. The Toronto Women's Medical College was opened by an introductory lecture by Dr. Barrett, the President, in the presence of the Mayor and a large gathering of ladies and gentlemen. Speeches were also delivered by the Mayor, Mr. Beaty, M.P., and Principal Caven. The attendance is small, but great hope is expressed in the future of the school. We have had no report from the Halifax Medical School, which opened as usual on the first of October, with a fair quota of students.

The attendance of students at the various schools is much above the average this year. In Toronto alone, there are nearly 400 students in the two schools, 235 being the number registered in Trinity Medical School.

JAMES A. SEWELL, M.D., EDIN.

It again becomes our painful duty to announce the death of one of Canada's oldest and most respected physicians, Dr. James A. Sewell, of Quebec, who died on the 2nd ult., at the advanced age of 73 years. He was a son of Chief Justice Sewell, and was born in Quebec, in 1810, where he received his early education. After receiving his professional education in Edinburgh, where he graduated in 1833, he settled in his native city, and has been engaged in the practice of his profession for upwards of half a century. He was also actively engaged in medical teaching in connection with Laval Medical School, of which he was

Dean and Prof. of Practice of Medicine. For upwards of 40 years he has been one of the attending physicians of Hotel Dieu, and also for many years Chairman of the Marine Hospital Commission. As one of the Governors of the College of Physicians and Surgeons of Quebec, he took an active interest in its affairs, and also in promoting the welfare of the profession. As President of the Quebec Medical Society, he was Chairman of the meeting called to organize the Canada Medical Association in 1867, and in 1871 he was elected President of the Association. During the troubles of 1837-8 he was attached to the Royal Volunteer Artillery. In his younger days he contributed many articles to the *Canada Medical Journal* and *British American Journal*. In his death the people of Quebec and the profession in Canada have lost an old friend, a useful man, and a physician of the highest skill and attainments. His kindness of heart, amiability and gentleness of disposition endeared him to all classes, and he will be greatly missed in the community where he was so well known and beloved. He has left behind him a beautiful and touching memory which will long endure.

Dr. Sewell leaves behind him a large family. Two of his sons have followed in their father's footsteps, both being graduates in medicine of Edinburgh. One is in practice in England, and the other, Colin C., in Quebec. The members of the family have our most heartfelt sympathy and condolence.

QUEBEC MEDICAL BOARD.—The semi-annual meeting of the above-named medical board was held in Quebec, on the 26th of Sept. Present, Dr. Lemieux, President; Hon. Dr. Ross, Vice-President; Drs. Belleau and Campbell, Secretaries; Dr. Lachapelle, Treasurer; Dr. Larue, Registrar; Hon. Dr. Robitaille, (Lt.-Governor); Drs. Lanctôt, Duchesneau, Kennedy, Hart, Guay, Marsden, Gingras, Howard, Leprohon, Rodger, Ross, Mignault, Grandbois, Marquette, Lafontaine, Ladouceur, Parke, De St. George, Russell and Rosseau.

After routine a resolution of condolence was passed respecting the death of Dr. Laberge, M.P.P., a former Governor.

A committee consisting of Drs. Campbell, Du-

chesneau, Lanctôt, and Trudel was appointed to enquire into the complaints regarding the large number of rejections at the preliminary examinations.

The following gentlemen were appointed to conduct the examination of candidates for the license: Dr. Howard, Medicine; Dr. Ross, Surgery; Dr. Rodger, Midwifery; Dr. Kennedy, Anatomy; Dr. Parke, Physiology; Dr. Rosseau, Materia Medica; Dr. Guay, Chemistry; Dr. Mignault, Jurisprudence; Dr. Lanctôt, Botany and Hygiene. Four candidates presented themselves, one of which only, was successful, viz., Dr. A. D. McMillan. The committee on credentials examined the diplomas of the following gentlemen, and finding the same to be correct, granted them the license; Drs. N. Morency, E. Perron, C. Tessier, E. Sylvain, G. W. Lachaisne-Jolicœur, W. G. Thompson, H. Archambault, J. F. Peladeau, J. F. Prudhomme, A. J. Hopkins, A. Gauthier, L. A. Moll, J. Stewart, E. Bastien, G. F. Prevost.

The preliminary examination of the College was held in Quebec, from the 20th to the 22nd of September. There were forty-seven candidates, of which only nineteen were successful.

INFRINGEMENT OF TRADE-MARK.—By a decree of the supreme court of Rhode Island, issued in July, 1881, the manufacturers of "Hughes Acid Phosphate" were enjoined from offering for sale "Acid Phosphate" so-called, which was an imitation of Horsford's Acid Phosphate. Quite recently they have been fined \$600 for violation of the above injunction, and the Rumford Chemical Works Co. warn all persons from selling any imitation of their preparation, as they will by so doing render themselves liable to an action for damages.

FELLOWSHIP DIPLOMAS, TRINITY COLLEGE.—Students and graduates of Trinity Medical College will be pleased to learn that the Fellowship Diplomas of the School have been recognized by the Royal College of Surgeons, Edin. The holders of these diplomas will thus be entitled to the same privileges as are accorded to holders of Degrees in Medicine from Colonial Universities. These privileges consist in the exemption of candidates for the license of the College from passing the preliminary examination and also the examination in the primary branches required for this diploma. Other similar institutions in Great Britain will no doubt accord the same privilege.

APPOINTMENTS.—Dr. Fred W. Borden, of Can-
ning, N.S., has been appointed surgeon to the
68th Kings' Co. Infantry, *vice* Dr. Shaw, deceased,
and Dr. H. B. Webster, of Kentville, N.S., assist-
ant-surgeon. Dr. Samuel Primrose, of Lawrence-
town, N.S., is to have the rank of surgeon-major of
the 69th 1st Annapolis Infantry, from Sept. 10th,
1883.

Dr. H. Merrill has been appointed attending
physician at the Hotel Dieu, Montreal—G. W.
Anglin, M.D., Kingston, has been appointed house
surgeon to the Royal Infirmary, Edinburgh.—
Dr. Coburn has been appointed medical and statis-
tical health officer for Fredericton, N.B.

Dr. W. H. Henderson, of Kingston, has been
elected a life member of the Ophthalmological
Society of Great Britain and Ireland. He has
also been recently appointed to the chair of His-
tology in the Kingston Medical School. We re-
gard the appointment as a good one, and calculated
to reflect credit upon the school.

THE BULWER TRAGEDY.—Contrary to general
expectation, the jury in this case acquitted Mrs.
Coates of the murder of her husband by the ad-
ministration of strychnine. The evidence pointed
very strongly to the guilt of the woman, and the
judge charged strongly for conviction; but the jury
ignored his charge and acquitted the prisoner, be-
cause there was a doubt on their minds, owing to
alleged carelessness in conducting the *post mortem*,
as to whether the husband's death was caused by
poisoning from strychnine, or from tetanus. It is
an unusual thing for criminal charges to fall through
from carelessness on the part of medical men in
the conduct of *post mortem* examinations, and
while we do not believe there was such careles-
ness as was alleged, we trust this case may be a
warning and incentive to all who may be called
upon in such cases to do their work most thor-
oughly and carefully.

PERSONALS.—Dr. J. Workman, of Toronto, was
elected an honorary member of the Italian Phren-
atric Society, at its 4th Congress, held in the city
of Voghera, between 16th and 22nd September.

Dr. Picault, of Montreal, was given a banquet
on the 20th of September, by the French societies
of the city, in commemoration of the 60th anniver-
sary of his arrival in Canada.

Dr. H. J. Harrison has commenced practice in
Cornwall, Ont.—Dr. W. Thornton is about to
commence practice in New Richmond, Que.—
G. S. Beck, M.D., M.R.C.S., Eng., of Peterboro,
has returned from Europe.

THE HOMEWOOD RETREAT.—This is the name
of a new private asylum for insane, just comple-
ted, in the city of Guelph, Ont. It will be under
the charge of Dr. Lett, former assistant-superin-
tendent of the Toronto Lunatic Asylum. Mr.
Langmuir, former inspector of asylums, is president
of the association. It is, we believe, now open for
the reception of patients, and will accommodate
about 50. Full particulars may be obtained on
application to Dr. Lett, Asylum, Toronto. We
commend the institution to the favorable consid-
eration of the profession in Canada.

INSTANCES OF EXTRAORDINARY FECUNDITY.—
F. P. Atkinson, Surbiton, Eng., publishes in the
British Medical Journal for Sept. 15, 1883, the
case of a lady of good position, who was married
at sixteen and died at sixty-four, who had *thirty-
nine* children all by the same husband. There
were thirty-two daughters and seven sons with only
two sets of twins. All the children attained their
majority.

In the London Hospital Reports, Vol. I., 1864,
it is reported that Mrs. W., now a nurse in the
Hospital, was married in 1839, at 21 years of age.
In nineteen years (*i.e.* in 1858), she had borne
twenty children, *viz.*, eight single births, three times
twins, and triplets twice.

CHROMIC ACID AS A CAUSTIC.—Dr. Squibb
says chromic acid is a valuable caustic, "because
it is self-limiting in its action in a degree that no
other destructive caustic is. It is an active oxi-
dizing agent and destroys the tissues to which it is
applied by oxidation. In this respect it is like
other caustics, as nitric acid. But every molecule
of chromic acid which destroys a molecule of or-
ganic tissue is itself destroyed and rendered inert
by being reduced to an insoluble oxide of chro-
mium; and this principle and degree of self-limita-
tion is not obtained from any other caustic."

HARVARD CENTENNIAL.—The centennial cele-
bration of this well-known medical school was
held on the 17th ult., and was a most successful

affair. An instructive and eloquent address was delivered by Dr. O. Wendell Holmes, and speeches by President Eliot, Dr. H. W. Williams, and Col. Henry Lee. The following representatives were present from Canada, and were invited to seats on the platform: Drs. Mullin, Hamilton; Aikins, Toronto; Howard, Campbell and Osler, Montreal; Atherton, Fredericton, N.B. An excellent collation was served after the close of the proceedings. In the evening a reception was given to the guests of the day at Young's Hotel, and refreshments served.

DISEASES OF THE SKIN.—Dr. Bulkley, of New York, will give a seventh course of lectures on Diseases of the Skin, in the New York Hospital, Wednesdays, at 2.30 P.M., commencing October 17th, 1883. The lectures will cover the entire subject of Diseases of the Skin (including Syphilis), and will be fully illustrated by colored plates, photographs and clinical cases. The course will consist of twenty lectures, and will be *free* to practitioners of medicine and medical students.

KERN'S POULTICES IN LYMPHO-SARCOMATA.—Prof. Busch, of Bonn, recently delivered a clinical lecture on the use of Kern's poultices in this disease. Kern's poultices consist of one part of mustard flour to five parts of black soap, the mixture to be enclosed in a gauze bag and applied to the growth for four or five hours every day. It produces intense irritation almost resembling erysipelas, and causes the tumor to soften and disappear.

SANITARY CONVENTION.—The Ontario Board of Health will hold a sanitary convention in London, Ont., on the 16th and 17th inst. Papers will be read upon various subjects connected with hygiene, and sanitary appliances of various kinds will be on exhibition. This is the second meeting of the kind in Ontario; the former was held in St. Thomas.

A NEW MEDICAL COLLEGE.—Steps have been taken by the profession in Winnipeg towards the establishment of a medical school. An act of incorporation will be applied for at the next session of the legislature. The names of the following gentlemen are mentioned in connection with

the movement: Drs. Codd, Kerr, Wilson, Jones, A. H. Ferguson, Patterson, Brett, Whiteford, Good, Blanchard, R. B. Ferguson and Sutherland.

OUR attention was recently called to the advertisement of Dr. Kane, of New York, in which he claims to cure the opium habit by a combination of remedies not named. Upon receipt of his circular, we became fully convinced of the character of the advertiser, and have to express our regret that the advertisement appeared in our columns.

ROYAL PRESENTATION.—Her Royal Highness the Princess Louise, before leaving Ottawa, presented Dr. Grant with a very handsome despatch box as a recognition of his kind services to her during her sojourn in Ottawa. Mrs. Grant was also the recipient from Her Royal Highness of a very pretty candelabrum.

OLD ANNOUNCEMENTS.—If any of our readers happen to have announcements of the old medical department of Victoria College for 1858-9, and for 1860-61, they would confer a favor by forwarding the same to this office. They are wanted to complete sets which are being made up for a college library.

BRITISH DIPLOMAS.—F. C. Astley, of Onslow, Que., has taken the L.R.C.P., Edin., and was subsequently elected F.O.S., Edin. Drs. J. E. Jenner, E. M. Hoople, and L. Backus (Trinity), and Dr. Doulson (Toronto), have passed for the L.R.C.P., London.

HARVEY'S REMAINS.—The remains of Dr. Harvey, discoverer of the circulation of the blood, have been recently removed from the vault at Hempstead in which they have lain many years, and placed in a sarcophagus in the chapel. The object is to insure protection against desecration.

REMOVALS.—Dr. Jas. Grange has removed from Peterboro' to Napanee. Dr. N. E. Chevalier has removed to Iberville, Que. Dr. A. McLeod has removed to New Westminster, B.C.

M.D., TORONTO UNIVERSITY.—Dr. R. E. Clapp, of Harriston, Ont., received the degree of M.D., Toronto University, at a meeting of the Senate on the 28th of Sept.

Books and Pamphlets.

A TEXT-BOOK OF GENERAL PATHOLOGICAL ANATOMY AND PATHOGENESIS, by Enst. Ziegler, Prof. of Pathological Anatomy in the University of Tubingen. Translated and edited by Donald McAlister, M.A., M.B., Cambridge.

This is a valuable compendium of the present knowledge of the various subjects embraced in the work, and it is well-deserving of patient study by every member of the medical profession who desires to keep up with the march of modern research. It is illustrated by 354 figures, some of which are executed in a very instructive form. The lettering in a few instances is defective or obscure, but considering the cheapness of the book, as indeed of the entire series of the "Wood's Library," artistic criticism should be very mild; and when we consider the impossibility of producing exact representations of morbid structures, which should serve as reliable illustrations of the ever varying phases and the endless varieties of pathological conditions, our appreciation of these productions of art must be very materially qualified. The student who derives his impressions of the pathological aspect of diseased structures from attractive plates and figures, (and very often the more attractive and dazzling all the more deceptive,) must find, when confronted in the autopsical theatre with the real objects, that he has been on the wrong road to useful knowledge. The English dress in which the translator has presented this work is truly charming. The style is faultless. If the rendering of the text is as accurate as it is pleasing, Dr. McAlister has done his part in a masterly way.

LECTURES ON FEVERS, by John R. Kippax, M.D., LL.B. Chicago; Gross & Delbridge. pp. 440.

These lectures contain the substance of the course on fevers delivered in the Chicago Homœopathic College during the session of 1882-83. The etiology, clinical history, differential diagnosis, and morbid anatomy, is given very fully and in a very attractive way, so that both those who attended the course, and those who read the work, cannot fail to be greatly benefited by it. The style is clear and concise, yet sufficiently full and complete. The exposition of the history and clinical character of the diseases treated of are on a level with the science of to-day. We only wish we could say as much for the treatment, but of course in regard to this there must of necessity be a difference of opinion.

ELEMENTS OF HISTOLOGY. By E. Klein, M.D., F.R.S., Joint Lecturer on General Anatomy and Physiology in the Medical School of St. Bartholomew's Hospital, London. Illustrated with one hundred and eighty-one engravings. Philadelphia: Henry C. Lea's Son & Co. 1883.

This little work will serve a useful purpose as a ready reference book for students and practitioners of medicine. The style is clear, and although the remarks upon each subject are very brief, they are nevertheless very complete. The book is well illustrated for a work of its size and pretensions.

QUIZ COMPENDS—Medicine, by Dr. Hughes; Surgery, by Dr. Horwitz; Anatomy, by Dr. Potter; Physiology, by Dr. Brubaker. Philadelphia: P. Blakiston & Son. Toronto: N. Ure & Co., \$1 each.

These little manuals are very well adapted for the purpose intended, and will be found useful as aids to the memory of the student and practitioner.

THE COLLECTIVE INVESTIGATIONS OF DIPHTHERIA. As conducted in the Detroit Therapeutic Gazette. With editorial summary. Detroit, Mich.: Geo. S. Davis, Publisher, 1883. pp. 120.

INDEX-CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE, U.S. Army: Vol. IV. E.—Fizes. Washington, D.C.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA—Thirty-fourth Annual Session, vol. xv.. Philadelphia: Collins, printer.

Births, Marriages and Deaths.

On the 2nd ult., W. Claxton, M.D., of Verona, to Edith Augusta, eldest daughter of Allen Bond, Esq., Inverary.

On the 18th ult., J. M. Johnston, M.D., etc., of Belmore, to Miss Emma Bland, youngest daughter of Luke Bland, Esq., of West Zorra.

At Amherst, on the 10th ult., R. Ripley, M.D., aged 46 years.

At Carp, Ont., on the 4th ult., T. A. Kidd, M.D. (Trinity), aged 25 years.

At Pine Orchard, Ont., on the 12th ult., Playter May, M.D., (Trinity), aged 26 years.

At Lifford, Ont., on the 24th ult., A. B. Wilson, student of Trinity College, aged 24 years.

* * * The charge for notices of Births, Marriages and Deaths is Fifty Cents, which should be forwarded in postage stamps with the communication.

THE CANADA LANCET.

A MONTHLY JOURNAL OF

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CRITICISM AND NEWS.

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Original Communications.

PROPHYLAXIS OF THE VENEREAL DISEASES, AND ESPECIALLY SYPHILIS.

BY DR. J. SORMANI, PROFESSOR OF HYGIENE IN THE
UNIVERSITY OF PAVIA.

Translated by J. WORKMAN, M.D., Toronto.

Introduction.

The August number of the *Revista Medico-Quirurgical*, of Buenos Ayres, presents a continuation of the above work, translated from Italian into Spanish. The subject is of momentous importance, and it is very desirable that every member of the medical profession, or in truth every member of society, should be made acquainted with the terrible consequences which have everywhere resulted from the neglect of adequate sanitary measures for the prevention of the spread of one of the most, if not verily *the most* destructive maladies that has ever fallen on the human race. The plague, cholera, smallpox, yellow fever, scarlatina and diphtheria are all fearful diseases, but even when they terminate in death, there their havoc culminates. How different is it with syphilis! Who can tell to how many generations it may be transmitted, or how innumerable may be its innocent inheritors? Few medical practitioners can be ignorant of the distressing morbid complications with which from time to time they are confronted, and against which they have to contend,—the unequivocal, and too often indomitable, constitutional residuaries of the syphilitic virus. Were all medical practitioners who are competent to form a reliable diagnosis, to register with unswerving accuracy the causes of death, it is beyond all doubt that inherited syphilis would stand much higher in our tables of mortality than it has yet

done. Very few practitioners meeting with these cases ever venture to inform the friends of such patients of the real nature of the disease. No sensible person can find fault with their reticence. The peace of families would be destroyed by a different course, and the rational treatment of the disease could not be benefited by unprofessional garrulity. But when physicians are called upon for their decision as to the best means for the prevention of disease, and especially of one so destructive as syphilis, they should exhibit the "courage of their opinions," and give no uncertain sound of their convictions. It is a most unquestionable, and at the same time a most lamentable fact, that the most strenuous opponents of legislative provisions for the prevention, or the lessening, of the diffusion of syphilis, are women,—the very individuals who have the deepest and most immediate interest in the carrying out of preventive measures. Medical practitioners are not blameless in this relation; they might declare their views without descending to individual proofs. Perhaps when our ranks become strengthened by recruits from the other sex, the antagonists of common sense will learn more than they now know.

Translation.

"The city in which sanitary regulations in relation to these diseases are most rigorously enforced, is certainly Brussels, and it is in this city that the smallest proportion of cases of syphilis exists. Dr. Jannsens asserted, in the International Congress of Hygiene in 1876, that only one or two cases in the whole year are met with among prostitutes. Professor Thiry, in the meeting of the Society of Public Medicine in December, 1880, stated that the cases met with were almost always those of newly arrived English women; this proves that vigilance over prostitution has a direct and certain influence in diminishing the manifestations of venereal contagion, and especially that of the syphilitic virus, which should command our earnest attention. It is objected, with a show of reason, that the vigilant visitation falls on only 100 women, whilst ten times as many pursue the vocation clandestinely, and escape detection; consequently the benefit derived must be trivial. The opponents therefore say that an advantage which costs so many sacrifices of the liberty and modesty (!) of the poor prostitutes subjected to visitation should be renounced. Surely this sort of argument can convince

nobody. The registered prostitutes do not constitute the whole nor even a majority of the entire class, but these are the most prostitute of the prostitutes, the poorest, the most depraved and the most frequented by persons of bad life, and they have intercourse with men of their own class, thus irreparably and very extensively contaminating the lowest strata of society. On the other hand it may be observed, that the visitation made to those registered is useful to the clandestine class also, who derive an indirect benefit, as has been observed in England, in the cities which have not (?) been subjected to the orders relating to contagious diseases.

" In 1850 the police in Paris arrested clandestine prostitutes ; among these syphilitics were found in the proportion of 40 per cent. In 1834 the proportion was 31 per cent. (*Parent-Duchalet*). From 1861 to 1866 the proportion went down to 27 per cent. (*La Fort*). In Milan the clandestine prostitutes inscribed were found infected in the proportion of 95 per cent. ; the proportion gradually diminished, being in 1873 reduced to 49 per cent. In Turin, according to Dr. Catella, the infected clandestine prostitutes in 1848 were in the proportion of 62 per cent., in 1855 they were 30 per cent., and in 1879, 18 per cent. A similar result was observed in Strasbourg : in 1853 this service was devolved on the police ; it had previously been very defective : the new director caused the arrest of a great number of prostitutes. In the visitation 83 per cent. were found to be infected, but in the succeeding years the proportion had so much decreased that, in 1856, the proportion was only 32 per cent. The same fact was confirmed in Bordeaux ; in 1858 the diseased clandestine prostitutes were in the proportion of 49 per cent. : the service was reorganized in 1859, and in 1860 the proportion had descended to 20 per cent. If benefit results, even indirectly, from the sanitary visitation of the non-inscribed prostitutes, it must with greater reason result to those women who are brought under the regulation. In a brilliant communication of Dr. Kuborn to the Royal Academy of Public Medicine, we read that from 1865 to 1870 the public women visited in Paris presented, according to Carlier, the following proportions : the clandestine, 27 per cent. ; the inscribed less than 2 per cent. infected.

" It is seen, from the statistics gathered by Dr.

Fidanza and reproduced by Dr. D. Benjamin Dupont in his *Pornographia* de Buenos Ayres, that, in this city, in which the sanitary vigilance over prostitution is almost nothing, there entered into the hospitals, from 1872 to 1877, 4,632 venereal patients, among whom there was a mortality of 4 per 1,000 in men, and 100 per 1,000 in women. The prostitutes of the low class, through ignorance or negligence, give no heed to their disease, and it consequently becomes sometimes so aggravated as to result in death. Well now, we have seen that in the cities in which sanitary visitation has been established, it is very beneficial under different aspects, *since it diminishes venereal diseases among the troops and prostitutes subjected to visitation*, whilst it is indirectly beneficial also among those not so subjected, and it attenuates in a marked degree the more grave form which occasions syphilis. It also appears that the venereal affections are propagated with more facility, according to the observance of Dr. Mauriac, by those not subjected to visitation ; he, after investigating the origin of the contagion in 4,735 venereal patients treated by him, found that 4,012 had been infected by non-inscribed women.

" Let us now look on the reverse side of the medal, at what takes place in London, in relation to this most interesting subject. In that city prostitution is free, and there are in it more than 50,000 prostitutes. These women are addicted to whiskey and gin, and they are to be met with in every street in the night, and frequenting all the cafes and beer and liquor establishments, and the vestibules of the theatres. They congregate in the brothels, or nocturnal houses, in the long rooms frequented by sailors, and in the hells where they are to be found in great numbers.—(*Ryan, On Prostitution in London, 1836*). In some parts of England there are obscene dens in which girls between 12 and 15 years of age, half-naked and almost dying of hunger,—prostitute themselves for a few pence.—(*Lecour, Prostitution in Paris and London, Paris, 1877*). In 1864 more than 6,000 women, who had no other mode of living than prostitution, appeared before the tribunals of London, for various offences. May we not now say to the English ladies of the confederation, 'give heed to the beam that is in your own eyes?' It is easy to understand why in London the consulting annexes of the Lock Hospital, Guy's Hospital, the Royal

free Hospital, University College, the Westminster and the Metropolitan free Hospital, are crowded with venereal applicants, for those admitted as in-patients are not numerous. In 1865 the syphilitics, aided in these hospitals, were 1,846.—(*Lecour*). It is besides calculated that 20 per cent. of those having affections of the eyes, presenting themselves at the Ophthalmic Hospital, have syphilitic infection as the cause. The Harveian Medical Society of London published in 1867 a report, in which was shown the great abundance of venereal affections and syphilis in that city. In the Hospital for Children it was seen that, in 1,000 surgical cases, 93 boys and 106 girls were syphilitics.

"We have now seen that venereal diseases, and especially syphilis, abound in those places where prostitution is free and unwatched, but it may appear a paradox that these diseases multiply and assume aggravated form still more in those countries in which prostitution has been persecuted, and, if we should judge from appearances, abolished. I have already spoken of Rome, a city in which syphilis has made great ravages, and if any one desires to know what occurred there in the years from 1849 to 1870, he needs but to read the report of Dr. Jacquot, physician of the hospitals of the French army of occupation, in which he writes thus: 'Miserable creatures prostitute themselves nightly in the dark angles of houses, under the less frequented porticos, on the seats and borders of walks, and even in front of St. Peter's.' And what is certainly still worse: 'Prostitution in Rome is carried on in all parts, and, disgraceful to relate, frequently in the interior of families.' The city of Munich presents to us another example: in 1811 the Bavarian parliament passed a law by which severe penalties (from one month to two years' imprisonment) were inflicted on all women following prostitution. All the houses of tolerance were immediately locked up, and all visitation and medical inspection ceased; well, what followed? Whilst in the two preceding years the number of men and women with venereal disease admitted to the hospitals had averaged 1,006 yearly, in the five succeeding years the average rose to 1,500, and in 1866 it reached to 1,835,—almost double the number of diseased, and the houses of tolerance were closed and visitations suspended!

"These facts teach us another lesson, which relates to the proportion of venereal cases in the sexes. During the period of the tolerance and vigilance of prostitution, there entered the hospitals 203 men affected with syphilis for every 100 women, but when visitation was suppressed the figures rose to 335 men for every 100 women, which shows that the women did not voluntarily go to the hospitals when they were diseased, but continued spreading the contagion, regardless of the sad consequences. The director of the Syphilitic Hospital of Hamburg also states in his report, that after the suppression of the houses of tolerance, syphilis extended more among men than among women, as was observed in Munich. In January, 1876, there were in the hospital 63 men and 127 women, but in the corresponding month of 1877, five months after the suppression, there were in the establishment 104 men and 98 women. Visitation is then necessary under a hygienic point of view, principally for the woman, as a syphilitic man may infect only a small number of women, whilst a woman may transmit the disease to many men. Further, it is rare that a syphilitic man does not seek for treatment, but this fact is not observed in women; consequently as the prostitutes are not subjected to sanitary visitation, and in its place the system of absolute liberty, or that of prohibition is adopted, we see, under whichever of the two, how disastrous are the results both to hygiene and to morality.

"We must now give our attention to another gratuitous assertion, which has been made by the optimists of the Federation, and reproduced, I say it with concern, by some medical men: it has been affirmed with extreme flippancy that there is in reality nothing to be feared from syphilis, that it has lost the malignity which it had in the 15th century, that it is seldom mortal, and, in fine, that it is diminishing and has become very rare. What substantiality is there in these optimistic ideas? Let us examine the facts. It appears from the report of Dr. Bruckner, presented to the Reichstag in February, 1877, that during the year 1876, there were detained by the police in Berlin 16,168 women, of whom 879 had syphilis. In the same year 895 soldiers of the Prussian army affected with syphilis entered the hospitals, and in 1873-4, 2,982. Among the members of the societies of operatives in Berlin, there were 5,817 syphilitics in

1878. So syphilis yet exists in Prussia! Of the soldiers of the French army there entered the hospitals in consequence of syphilis, 2,638 in 1875, not including simple venereal cases; in 1876 the number was 1,864, and in 1877 it was 1,887, or in all, in the three years, 6,389. In five hospitals of Paris, 1,403 syphilitics were admitted in 1867, and 1,551 in 1868. In the city of Paris there died of syphilis in three years (1875-77), 476; or 8 to every 100,000 inhabitants, yearly. The city of Vienna, in 1876, registered 42 deaths from syphilis, or 6 per 100,000 inhabitants. In London, in the three years, 1846-8, 127 deaths from syphilis were registered; in 1866-8, the deaths registered from the same cause were 1,357, and in 1876-8 they were 1,376, or 13 per 100,000 annually of the inhabitants. In England and Wales the numbers given as deaths from syphilis were, in 1864, 1,550; in 1867, 1,698; in 1870, 1,858; in 1874, 1,997, and in 1878, 2,182. Deaths from syphilis are, then, very frequent in England, and they are constantly increasing. Let us now pass to Italy. I have, in my *Nosological Geography*, brought together the known statistics, in order to study the frequency of syphilis in Italy, of which I now proceed to present a brief summary. In the fourteen years, 1863 to 1876, 303 young men, coming chiefly from Lombardy, Campania and Sicily, were declared useless for military service, because laboring under syphilitic cachexia. In the period 1875-8, the number of deaths from syphilis in 18 Italian cities, reached the considerable figure of 1,708, of which the greater part were deaths of children under one year old. The figures for Rome, Naples, Padua, and Milan are very high, as will be seen from the following table:

DEATHS FROM SYPHILIS IN EIGHTEEN ITALIAN CITIES.				
Cities.	Periods.	Deaths.		Proportion, annually, per 100,000 inhabitants
		Total.	Yrly.	
Turin.....	1869 to 1876	79	10	1
Alessandria..	1875 " 1878	2	1	3
Genoa	1875 " 1878	41	10	6
Milan	1875 " 1878	97	24	9
Verona	1874 " 1878	43	9	13
Vicenzia	1875 " 1876	7	3	7
Padua.....	1872 " 1877	120	20	28
Udine.....	1873 " 1878	87	14	47
Venice.....	1875 " 1878	35	9	7
Rovigo	1877 " 1878	1	0	9
Bologna.....	1875 " 1878	52	13	11

Liorna	1876 to 1878	24	8	8
Rome	1874 " 1878	852	170	64
Naples	1875 " 1878	168	42	9
Lucca	1876 " 1878	10	3	12
Cocenza	1877 " 1878	3	2	13
Messina.....	1876 " 1878	76	26	22
Catania.....	1877 " 1878	11	5	6
		1708	369	

“With respect to the city of Turin, we have been able to establish interesting data and to see whether the mortality caused by syphilis had increased or diminished. In the ten years, 1828-37, 1,945 individuals, or 194 per year—on the average, died from syphilis; the city, suburbs, neighborhood and the garrison contained 124,000 inhabitants. In the more recent period, with over 214,000 inhabitants, it has had only 10 deaths per year from syphilis! Does this not indicate a very notable hygienic improvement? And has it not been brought about under the domination of the enforced regulations, authorizing vigilance over prostitution, and under the influence of other hygienic measures adopted for the purpose of limiting venereal affections? In the period, 1828-37, the mortality from syphilis was 156 in every 100,000 inhabitants, yearly; in the period, 1869-70, the number went down to 4 per 100,000,—a result obtained in only 50 years! We might, then, hope that in Rome, in the course of 15 or 20 years, the proportion of 64 per year in 100,000, might be reduced in like manner, though certainly not under the system of liberty, but of vigilance. Professor Gamberini states that he treated, in the syphilis hospital of Bologna, 19 syphilitic prostitutes in 1879, and 38 in 1880. In the establishments for venereal and cutaneous diseases, in Pavia, directed by Professor Scarenzio, according to Dr. Raimond, 261 cases of constitutional syphilis were treated in 1873-80.”

PNEUMONIA *

BY J. NEWTON SMITH, M.D., HAMPTON, N. E.

Pneumonia is, strictly speaking, an inflammation of the vesicular structure of the lungs, and may effect one or both lungs, or a part or whole of one lung. There are three recognized types of pneumonia, viz: Croupous or Lobar, Catarrhal [or

* Read before the New Brunswick Medical Society, in St. John, July 17th, 1883.

Lobular (or broncho-pneumonia), and Interstitial pneumonia. That form about which I propose to say a few words, is croupous pneumonia, and it is this form which is understood when we say that a person has pneumonia.

The etiology of pneumonia, like many other diseases, has a wide range. As regards age, the greatest number of pneumonia patients are between fifteen and forty years, the most favorable time in life to have it, other things being equal. Cases under five years of age, or between forty and sixty are not very numerous, although no age is exempt from it. As a person reaches sixty and upwards, he is more likely to take the disease when exposed to the cold, or any depressing influence that would be likely to act as an exciting cause. There are many exciting causes well-known to us all; but there are two points in the etiology of the disease that might be profitable for us to consider, viz: 1st. What may those unknown atmospheric changes be, which act as exciting causes in epidemic pneumonia? and, 2nd. Is pneumonia under no circumstances a contagious disease? As regards the unknown atmospheric changes which act as exciting causes, it is a fact known to us all that pneumonia occurs as an epidemic, under some peculiar condition of the atmosphere, the theory of the nature of which has not yet been established; but were it established, it might be of material benefit in the prophylactic treatment of the disease. We might with propriety ask ourselves, "How shall we attempt to unravel the mystery?" And yet, may it not seem reasonable to suppose that we have some basis for the theory, that an atmosphere containing an excess of ozone, is the exciting cause of epidemic pneumonia in many cases, from the very fact that the apparent condition of an atmosphere which favors the development of pneumonia, is likewise favorable to an excess of ozone. The results of various observations have shown this to be the case. We are also aware that ozone is a highly irritable, poisonous gas, and air that is charged with it, is irrespirable. It somewhat resembles chlorine gas in its effects upon the human subject. Its odor is so powerful that it can be recognized in air containing only one millionth part of the gas. Now, the constant inhalation of such an irritable gas, even in very small quantities, cannot fail to produce injurious effects upon the breathing apparatus to a greater or less extent. There is present

in the atmosphere a greater amount of ozone in the winter than in the summer, in damp cold weather than in dry cold weather, and there is likewise more found in the country than in the city. So is it true of pneumonia; it is more prevalent at such times, at such places and under such conditions as I have mentioned, all going to prove that the conditions which favor the development of ozone, also favor the development of pneumonia. The question might very properly be asked,—Why is it that we have more ozone in the country than in the city? The question is easily answered, when we bear in mind that ozone is a great natural disinfectant. It seizes hold of all miasma wherever it is generated and purifies the air in proportion to the amount of ozone that is present. So in the country, where the air is naturally free from impurities, very little ozone is sacrificed in disinfection; but in towns and large cities, there is such an abundance of impure gases, that the ozone is soon exhausted in counteracting the effects of an atmosphere contaminated with impurities. Hence the reason why a wind bearing ozone is felt in its effects only at the outer portion of a city where it strikes. So it seems to be with pneumonia; the outer portion of a city that is more directly exposed to an eastern or western wind, is more liable to an epidemic of pneumonia than the interior of a city, and still more so is the country than even the outer portions of a city, taking into consideration the sparsely settled country in comparison with the densely inhabited city. From these as well as other facts concerning ozone, I think we might reasonably conclude that it certainly has something to do with the occurrence of epidemic pneumonia.

Having spoken of pneumonia as an epidemic, I wish now to ask the following question:—Is pneumonia under no circumstances a contagious disease? I believe this question has always been answered in the past in the negative—that it is not a contagious disease. I think, however, that at least some of you during the past year must have been led to believe that it sometimes seems contagious, although it never has been considered so before. A number of cases have come under my observation during the past nine months, which almost convinced me that it could really be conveyed from one person to another, from the manner in which the different members of the family

contracted the disease. They were all alike exposed to the same influences at the same time, and yet one after the other took the disease, seemingly in the order in which they were the most directly in each other's presence. And in all of these cases, no other symptoms manifested themselves which would lead me to suppose that there were any morbid agents at work, other than those belonging to pneumonia. I have noticed through the medical journals that others have made the same observations, and if there be any present who have had the same experience, I would be glad to hear from them.

The symptoms and differential diagnosis of pneumonia, although of great importance to the practitioner, are so well understood by us all, that it is not necessary to say anything about them; but I desire to say a few words respecting the prognosis and treatment of the disease in question. It is comforting for a physician to be able to prognosticate with approaching exactness, the severity, daily development, and probable termination of a disease even of the gravest form; for though our efforts to save life are in vain, under such circumstances we do not lose the confidence of those who employ us, and we have the consoling thought that we have done our duty, and that we have not lost our patients either through neglect or lack of professional skill; but by a superior power over which we have no control. There are many things to be taken into account in order to enable us to give a correct prognosis in pneumonia—among which we may mention age, constitution and habits of the patient, all of which are of great importance. Occurring in the young child, or in a very old person, it is almost always fatal. According to well authenticated statistics, between the ages of 40 and 70 years, the death rate is between one in five and one in seven. On the other hand its lowest mortality is between the ages of 10 and 30 years. Between those ages the majority will recover, if other circumstances be favorable. If a person be addicted to drinking habits, or is of a feeble constitution, or suffering from any serious organic disease, especially of the heart, lungs or kidneys, the prognosis is unfavorable, in proportion to the extent of these diseases, or to the excess of vicious habits. The prognosis is likewise dependent upon the amount of lung involvement. Pneumonia is attended with very great danger when the patient

is in a pregnant state, although the lung be only partly involved. Among the individual symptoms which indicate danger might be mentioned, high temperature, absence of expectoration in the second and third stages, with loud tracheal rales, or a copious liquid, prune juice, expectoration; or extreme prostration in any stage of the disease, followed by a cold clammy sweat, are all indicative of great danger. It is said by good authors, that if the pulse reaches 150 per minute, the case is almost certain to be fatal; but we should not give up our patients even though it should temporarily reach above that point, for there are exceptional cases where the pulse exceeds that for a short time and recovery takes place. I myself have met with a case in which the pulse at one time exceeded 150, and the blueness of the lips and ends of the fingers gave strong evidences of cyanosis, yet the patient recovered. Another unfavorable symptom is that of pulmonary congestion. When there is pulmonary congestion in the portions of the lung which are not involved, there is great danger, as this condition is frequently the direct cause of death.

As regards the treatment of pneumonia I shall not detain you long; but refer to some of the means which are adopted for the cure of this disease. In mild cases we should adopt the expectant plan of treatment; put our patient in a warm airy apartment, and wait for the symptoms which we may be called upon to treat. Unfavorable symptoms which may arise under these circumstances, will yield more readily to the proper kind of treatment, than they would had the patient been subjected to a regular routine course before those symptoms were manifest. I would not, however, recommend that we lose sight of our patient, and trust to friends to let us know when our services are required. We should watch him closely and give nature the necessary aid at the proper time. It is likewise necessary that we should attend to the general comfort of the patient, not forgetting that he requires plenty of fresh air, the temperature of which should range from 68° to 70° F.; abundance of easily digested food should be given, such as milk, beef tea, and where the stomach can tolerate it, fresh eggs can be given with advantage. It is also of vast importance to insist upon the patient protecting the chest from sudden changes of heat and cold, and to prevent all exposure to draughts. If these rules are pro-

perly carried out the patient will be likely to recover, without resorting to active measures; provided that none of those unfavorable conditions exist which I have mentioned in the prognosis. On the other hand, if the patient be not convinced of the importance of observing these rules, he may ignorantly involve himself in much danger, which otherwise might have been avoided.

In a severe case of pneumonia, there are usually two conditions which we wish to remedy, viz: a high temperature and feebleness of the heart's action. Various means have been adopted for the reduction of the temperature. For the accomplishment of this end, the Germans think that they have all that is necessary, in the cold compresses, which they apply freely to the chest; believing that it will not only reduce the temperature, but hasten the critical day that we speak of in pneumonia. It is well-known to those who have resorted to this means, that it does momentarily relieve all the distressing symptoms; but as soon as the compresses are taken off, or otherwise neglected, the symptoms return with increased intensity. Besides there is a great risk of the patient being chilled, and the pneumonitic process extending; hence I think we should not attempt to reduce the temperature or relieve the local symptoms in this way.

Many again use aconite and veratrum viride to lower the pulse and temperature as well; but these likewise have only a temporary effect, and cannot be continued for any length of time in most cases, without producing gastric trouble, and very often great prostration. The veratrum viride especially produces this effect, chiefly on account of its nauseating nature.

Now, the cause of the high temperature in all acute inflammatory diseases, is the rapid molecular metamorphosis, or wasting away of the animal tissue in small particles. Bearing this fact in mind, it is well for us in looking for a remedy to endeavor to find one that will not only reduce the bodily temperature, but check the molecular change that is the cause of the excessive heat. It is said that quinine will do this—and we all know its great value as an antipyretic—therefore I think quinine should always have the preference in such cases. If quinine be given in the usual antipyretic doses, it will seldom fail to show its good effect in pneumonia, in, from 24 to 36 hours, while it shortens the febrile stage, and hastens the period of resolution.

The second thing to be accomplished in a severe case of pneumonia, is, to sustain the enfeebled heart, for most of the deaths in this disease are directly due to heart failure, or indirectly to passive pulmonary congestion. The administration of alcoholic stimulants is the most effectual means for this purpose; but they should be used with the same caution as any other drug; for, if given when the pulse does not show by its rapidity and feebleness that they are indicated they may do a great deal of harm. Therefore we should carefully watch the pulse, and thereby ascertain the force of the heart's power, and give it only in quantity to meet the demand. For excessive feebleness it should be freely administered, for moderate weakness only a small quantity. In short, we should not depend upon book knowledge, or the experience of others; but upon our own judgment as regards when, or in what quantity our patient should be allowed alcohol, if we wish success to crown our efforts. Another stimulant which is much given by some, is carbonate of ammonia which I believe is very efficacious in extreme cases, and where syncope is threatened. When there is an indication for an immediate stimulant, the carbonate of ammonia is preferable to alcohol, although the use of the one will not necessarily prevent us from using the other as well. On the other hand if we wish to continue the carbonate of ammonia for any length of time, it is objectionable on the ground that it acts as an irritant to the stomach, hence I think we should not carry it too far, especially should the gastric symptoms contra-indicate its continuance, for in such cases it will injure the patient, and diminish his chances of recovery.

The palliative measures used in pneumonia are various; I shall not detain you long in speaking of them, but offer a word of caution. We cannot be too careful in using narcotics in this disease, although it is sometimes necessary to give them in moderation. It is dangerous to give opium in any form, if the pneumonia be extensive, for small doses have been known to produce great prostration, and complete narcotism. We should never administer opium, even in very small doses, when there seems to be a tendency to loss of muscular power of the bronchi; but in such cases belladonna is often of service, and should always be given instead of opium when there is a contracted pupil. On the other hand if there be severe pain in the affected

side, and very distressing cough, and no contra-indication to its use, then opium may be given with advantage in small doses, the hypodermic injection being the best way to administer it. In cases where there is restlessness, and opium cannot be given, chloral in small doses will produce sleep, and act beneficially upon the cough as well. Many use expectorants in pneumonia, while others claim that they are of no service on the ground that the accumulations within the bronchi are due to the loss of muscular power to free themselves, hence expectorants cannot remedy the difficulty. So when this condition exists, belladonna can be given with advantage, as this drug gives tonicity to unstriated muscular fibres.

Poultices if properly used are of service in hastening the period of resolution, promoting absorption and aiding in expectoration.

In conclusion, a word might be said about counter-irritants. Some strongly recommend them in the early stage, while others condemn them on the ground that they only increase the distress of the patient, without being of any benefit. I think, however, all will admit that when there is considerable pleuritic effusion, or when the period of resolution is delayed, counter-irritants are of great service.

PROPHYLAXIS AND TREATMENT OF ANGINA TONSILLARIS.*

BY DR. JEAN GINÉ, Y PARTAGAS (Professor of Clinical Surgery, Barcelona).

(Translated by Dr. C. W. COVERNTON, M.D., M.R.C.S., Eng., Toronto, Ont.)

There are numerous abortive remedies for the treatment of certain pathological conditions, which might be separated from the domain of therapeutics to be inscribed in that of hygiene. In this list are to be found all those agents which produce a rapid disappearance of a pathological condition at its onset, without proving dangerous to the subject of it. If for example we were acquainted with a powerful and efficacious abortive of eczema, we should accord it no consideration as a hygienic measure; we should not advise that its use and management should be within the reach of all, because in certain cases, eczema is repelled to the

grave detriment of the bronchial and digestive passages. The same may be said of erysipelas, although in this case a solution of silicate of potash has proved of great service, as it does not act in repelling the phlegmasia, but rather in extinguishing the local inflammation, which in my opinion is the cause of the general symptoms that have occasioned this disease to be considered by many practitioners as essentially an internal affection. To be entitled to the term hygienic an abortive remedy should fulfil the following conditions: 1st. The substance employed should be entirely innocuous to the animal economy. 2nd. The immediate resolution of the affection should not entail any morbid consequences. These two conditions are fulfilled in bicarbonate of soda as an abortive in angina tonsillaris, applied in substance to the surface of the inflamed tonsils, from the commencement of the pathological process. I have found that the employment of this agent constitutes a practice worthy of receiving the sanction of hygiene, and of entering into the field of popular knowledge in order to protect the public from a frequent, painful and recurrent disease. My abortive method for simple tonsillitis rests upon a rational basis and has practical sanction. The rational basis is derived from an anatomical knowledge of the follicular glands of the tonsils, the physiological conditions, and the pathological nature of tonsillitis. (1) The closed vesicular glands of the tonsils are of a structure similar to those of the neighboring parts of the tongue and pharynx; but in the tonsils they are grouped in conglobate glands, the excretory ducts of which are to be observed at the bottom of certain anfractuosités and grooves in the free surface of the gland. The fluid which these glands secrete is essentially mucous, but it differs from that which is elaborated in the closed follicles of the base of the tongue, inasmuch as it ordinarily presents whitish masses of a pultaceous or tuberculous aspect, masses which, becoming more abundant in the acute phlogistic conditions, have occasioned lamentable errors from the confounding of a simple benignant angina with diphtheritic angina. (2) The physiological rôle of the tonsils, like that of the muciparous follicles of the base of the tongue and pharynx, is simply that of lubricating the isthmus of the throat and thus facilitating the passage of the alimentary bolus. The exudation of

* Read at the Fourth International Congress, Geneva, 1882.

mucus is accomplished by exosmosis through the three tunics which enter into the composition of the closed follicles. In the normal condition, this tonsil mucus is neutral or alkaline and sufficiently fluid. As soon as it loses its alkalinity, it thickens and is with difficulty eliminated from the follicles whence it is elaborated. Now if during the catarrhal phlegmasias so frequent in the tonsils, the secretion of the follicles becomes acid, it necessarily loses its fluidity, and no longer being able to pass out of the closed follicles, it accumulates in them and rapidly augments their volume, causing pressure on the vessels, nerves and stroma, and hyperæmia with strangulation, having a striking analogy with anthrax. Owing to the above conditions there is pain, increasing greatly each time the patient makes an effort at swallowing, ultimately fever, cephalalgia and the symptoms of concomitant gastric catarrh which characterize angina tonsillaris. The extension of the phlegmasia to the Eustachian tube gives rise to otalgic pains and to a certain degree of cophosis, to be explained by the presence in this locality of a group of muciparous follicles derived from the glands which form what are called the tonsils of the Eustachian tube.

Perhaps for my object I have dwelt unnecessarily on the pathology of angina tonsillaris, but I trust that the preceding details will be of service in explaining the action of bicarbonate of soda and the abortive influence it possesses. If the alkalinity of the buccal mucus is an essential condition of its fluidity, and if this quality is lost at the onset of catarrhal inflammation, it is evident that an alkali penetrating the cavity of the follicles will liquefy the mucus and place it in the necessary physical condition for transuding, the glandular retention will cease, and the affection will be immediately cured. This abortive action succeeds at an early period, often within twenty-four hours. When the follicles are already swollen, exercising compression on the stroma, the vessels and nerves of the gland, the secretion will no longer be the chief pathological element; but there will be more or less advanced inflammatory hyperæmia. Here again the alkaline remedy may be serviceable and lead to the evacuation of the follicles, but the inflammatory process already commenced will not terminate in speedy resolution, but will follow its course, more or less long, according to the

degree of inflammation. Finally, when the tonsillary inflammation has arrived at the highest degree and has propagated itself to the glandular parenchyma, the alkaline medication will have no influence.

The tonsillary phlegmasiæ are greatly disposed to relapse and to leave hypertrophy, with thickening of the mucous and chronic infiltration of the connective tissue. In this case the bicarbonate of soda, applied in the manner I am about to describe, will have a beneficial action and will prevent the necessity for the operation of tonsillotomy. In the initial period of free amygdalitis, characterized by slight pain in deglutition, the effects of bicarbonate of soda are as rapid as certain. It should be applied dry. If the patient is old enough he can make the application himself. It suffices to moisten the corresponding index finger of the side of the affected tonsil, to cover it as thickly as possible with the salt and then to place it on the affected tonsil so that the bicarbonate becomes adherent to it. The patient will remain for two minutes with the mouth open and without swallowing, so that the bicarbonate will remain a sufficient time in contact with the tonsil. It will soon be noticed that the salt liquefies on the mucous membrane and penetrates the follicles of the gland. Five minutes after, the application is repeated in the same manner, and continued every five minutes for five or six times. After that the patient may attempt to swallow and will be surprised to find that he may do so without inconvenience. From this moment the angina is aborted. It is unnecessary to say that, in the case of small children, this operation must be performed by means of insufflation. The nausea and the salivation that the presence of the finger and the contact of the bicarbonate in the throat produces, far from being detrimental, are powerful auxiliaries to the treatment, since the sudden contraction of the muscles favors greatly the evacuation of the muciparous follicles. Nevertheless, it is always preferable to operate when the stomach is empty, in order to avoid vomiting. When the symptoms of fever which indicate the ascending period of amygdalitis are established, with considerable tumefaction of the gland and sharp pains in deglutition, it will even then be desirable to try the bicarbonate as a resolvent to favor the evacuation of the muciparous glands, promote resolution and diminish the suf-

ferings of the patient. In these cases we may commence with the use of the salt in the hope of abortive action, but if after thirty minutes the angina shows no signs of resolution, it must be continued from hour to hour. If the angina arrives at its maximum of development, the bicarbonate does no harm, although it may be of no service. In the hypertrophic condition of the tonsils consequent on inflammation and its product, the bicarbonate perseveringly employed is again of great utility. Two or three applications daily, during one or two months, will occasion a gradual resolution of the hypertrophy. My method of abortive treatment by the bicarbonate has been known and practised for several years in Spain. I have employed it very often in my surgical clinic at Barcelona, and some of my pupils who have witnessed the treatment have also used it with success in their own practice. My friend and pupil, Dr. Armangue, of Barcelona, was the first to report his experiences. Some young physicians have published a small number of cases, which at first glance would appear to represent the efficacy as doubtful, but it is sufficient to state that one of the cases was one of diphtheritic angina, and that in two other cases the remedy was not employed at the commencement of the affection. Almost all the Spanish journals have published cases which incontestably favor the abortive efficacy and the resolvent action of bicarbonate of soda. The professor in his paper then related many cases from his clinical records (1) Of its successful abortive action in the initial stage. (2) Of cases where it was successfully employed in the first period of increase. (3) Cases in which hypertrophies to the extent of blocking up the isthmus of the fauces and consequent dyspnoea, were relieved by the persistent application for two months, three times a day, and the necessity for the operation of tonsillotomy dispensed with.

[Later reports from different sources confirm the value of this treatment in tonsillitis].—ED.

Correspondence.

VILIFYING THE PROFESSION.

To the Editor of the CANADA LANCET.

SIR,—I enclose you an advertisement, headed, "Betraying Confidence," which has appeared fre-

quently in Montreal and Toronto papers. The sentence following this glaring heading runs thus :

"It is very much to be regretted that the large majority of the so-called regular M.D.s will persist in discouraging poor sufferers, whom they have failed to cure, in trying the specialist, in whose hands lies their last and only chance to get well."

It is easy, I conceive, to understand from this, that by the "so-called regular M.D.," is meant the legally qualified practitioner, and "the *specialist* in whose hands lies their last and only chance," means in this case the presumptuous advertiser. The advertisement, as you will notice, is addressed to "anyone suffering from asthma, catarrh, bronchitis, catarrhal deafness, or consumption."

I hope, sir, you will consider it within your province to call attention to this underhand method of vilifying the profession.

I am, Sir, yours, etc.,

T. ARNOLD HAULTAIN, M.A.

Peterborough, Ont.

Reports of Societies.

TORONTO MEDICAL SOCIETY.

Sept. 27th, 1883. The President in the chair. After the reading of the minutes, Dr. Riddel presented notes of a very interesting case, with specimens. Miss C, æt 40, fell and injured her spine in 1875, but recovered without apparent bad effects. In 1877, she began to have difficulty in passing her urine, when examination revealed a tumor at the left side of the uterus, which, by pushing the bladder over to the right, partially occluded the urethra. Treatment for the relief of the unpleasant symptoms caused by the tumor being of little use, an exploring needle was used to determine the nature of the enlargement. As it seemed to be fibroid in character, anæsthesia was produced, an incision made just above the pubes, between the recti muscles, and the growth incised in several directions. Little blood was lost. The tumor gradually disappeared as a consequence of the operation, the pains ceased, and the urine was passed naturally. Five years afterwards, (1882,) Dr. R. was again called, and found a large hernia at the site of the wound made at the former operation. A truss was applied with only partial benefit; a few months later she complained much of what appeared to be sciatica, and a tumor appeared in

the *right* iliac region, and, a short time afterwards, one below Poupart's ligament, on the same side. January 1st, 1883, Dr. Aikins, saw her in consultation with Dr. Riddel, and considered the tumors to be malignant in character. In August last, the distension of the abdomen having become extreme, the trocar was used, very much venous blood escaping. As a consequence, the enlargement disappeared to a great extent, but the patient gradually sank, the tumor became gangrenous, and death took place about seven days after the operation.

The autopsy revealed the tumor occupying the right half of the abdominal cavity, the intestines being displaced to the left. It consisted of a sac filled with decomposed blood, the walls containing several spicula of bone. The right half of most of the lumbar vertebræ was necrosed, also the entire sacrum, the right ilium, and a portion of the right pubis; neither bladder nor uterus was seen.

Dr. Reeve presented a mucous polypus removed from the post-nasal region by means of long curved forceps passed up behind the velum, and with the aid of posterior rhinoscopy; and also shewed a modification of the Bosworth-Jarvis ecraseur which he had found of service in removing large adenoid vegetations from the vault of the pharynx. As urged in a paper before the Canada Medical Association in 1877, rhinoscopy should be practised in cases of nasal growths, and the snare should be used for ordinary nasal polypi in preference to the forceps, the latter being less effective and causing much more pain and injury than the former. After-treatment is of importance especially in view of the tendency to recurrence, and also on account of the possible transition of a benign growth into a malignant one, two instances of which had lately come under notice.

Dr. Ferguson showed a specimen from a case of necrosis of the femur. Five years ago, a lad, æt 9, was suddenly seized with severe pain on the inner and lower part of the right tibia. Abscesses formed, and during the following two years many spicula of bone were discharged. He was first seen by Dr. Ferguson in October, 1882. There was now pain and swelling of the lower end of the femur. The use of a probe revealed bare bone, expectant treatment was employed, and gradually a large piece of bone was detached. This was so loose in February, 1883, as to allow of removal. It proved

to be the entire diameter of the femur, and about three inches in length. The newly-formed bone could be felt grooved like a trough. The boy can now walk, and there is no shortening.

Case 11.—A lady, æt. 70, slipped and fell. The result appears to be some obscure injury. She can slowly elevate her head to an erect position; but if extension takes place beyond the perpendicular, control is lost; it drops suddenly backwards, intense pain being caused as far down as the sacrum.

October 11th, 1883. In the absence of the President and Vice-President, Dr. Covernton, was called to the chair.

Drs. Carson and Oliver were elected members.

Dr. Ferguson read a paper on "The Local Origin of Cancer," in which he endeavoured to show that cancer arises as a local disease, and from some form of irritation or injury.

Dr. D. Clarke, in discussing this paper expressed the opinion that only the tendency to it, not cancer itself can be transmitted from parent to child.

Dr. Oldright, referred to the fact that some authorities now hold peculiar ideas in regard to non-malignant tumors. Many now admit the possibility of secondary growths resulting from them. If this view were admitted, one of the most important points of difference between malignant and non-malignant tumors was removed.

Dr. McPhedran pointed out that the essayist had given the irritation of menstruation as a cause of uterine cancer. How did he account for cancer of the cervix, its mucous membrane not being shed at menstruation?

Dr. Ferguson considered that the irritation of engorgement was sufficient to account for it.

Dr. Cameron said that uterine cancers in virgins are found in the body, those of married females in the cervix usually. In the main he agreed with the opinions expressed in the paper just read.

Dr. George Wright mentioned the case of an unmarried female, the hymen being perfect, in which the cancer was cervical. He could not agree with Dr. Ferguson's paper and maintained the theory of a cancerous diathesis.

Dr. Macfarlane remarked on the curious fact that a prominent citizen of Toronto had smoked for forty years without developing cancer, while that gentleman's father had never smoked, yet had been operated on for epithelioma.

Dr. Reeve held that sarcomata may be successfully removed. He would insist on the early removal of all doubtful growths. The notion held by some that the removal of a tumor causes secondary growths is entirely erroneous.

At the close of the discussion the chairman announced that next meeting would be devoted to cases in practice, pathological specimens, &c.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.

The first meeting of the above-named society for the winter, was held on Friday evening, 26th Oct. The president, Dr. Robillard, City Health Officer, in the chair. After routine, Dr. H. S. Wright, read an excellent paper on London Hospitals, sketching his observations during a recent visit. Among other points he had remarked the universal custom of treating epilepsy with large doses of the bromides, and the indifference of most pathologists towards the *Bacillus Tuberculosis*. At Moorfields he was impressed with the careful manner in which the surgeons examined the eye for hardness before using atropine. They considered that glaucoma was often hastened by the indiscriminate use of this drug, due to its action on the ciliary muscle. In the discussion that followed Dr. Grant related a case of vomiting in early pregnancy relieved by a plaster of belladonna over the region of the stomach; many remedies had proved useless; no physiological effects had been noticed.

Dr. Prevost had seen small doses act powerfully, also large doses given with impunity. Remembered a case of strangulated hernia relieved in eight hours by a grain of the extract every hour.

Dr. H. S. Wright had seen an ordinary plaster produce alarming symptoms. In using the drug he never felt satisfied that it was of no service until the physiological effects had been produced.

The complications of enteric fever was selected for discussion at the next meeting, and Dr. Powell requested to prepare a paper on the subject.

The card of a local practitioner, with the following blank form on the back, was shown and caused much merriment:

To———
Address———

Having derived *great benefit* from the medical treatment of Dr. ——— I recommend you to secure his services.

Signed———

The growing custom of advertising as specialists in diseases of the various thoracic and abdominal organs was also discussed and disapproved.

Selected Articles.

EXSECTION OF THE HIP-JOINT.

Extracts from a Clinic by LEWIS A. SAYRE, M. D.,
New York.

GENTLEMEN: This man, M. M. D., æt. 37 years, was brought to my office a few hours ago by Dr. Barnes, of Binghamton, N. Y., who gave me the following history. Both parents and family are healthy. Patient was strong and robust until two years ago, and has been living on a farm; while ploughing, he has been in the habit of kicking the mud off the plough, and by this means the hip-joint has been injured, which has resulted in inflammation, and at the present time it has reached the stage of suppuration, with exfoliation of bone.

You will observe that the right limb is two inches shorter than the left, although the limb is perfectly straight owing to Dr. Barnes' careful method of applying extension. You will observe that there is one sinus in the groin, one below the crest of the ilium, one above the trochanter major, and another about three inches below; we have in all, four sinuses, and judging by appearances, they lead to dead bone; this you may know by their peculiar characteristic appearance, which is graphically described as representing the anus of a chicken. This dead bone is a source of irritation, and keeps up a constant discharge from the body, emptying itself by way of these sinuses. As time goes on, granulation commences around the borders of these orifices, and becoming exuberant, is recognized as proud flesh; in this case you will observe it presents this appearance. Whenever you find an opening of this description in such a case as is here before you, you may be certain that such an opening leads to dead bone; you may be positive upon this point. In probing these sinuses, a flexible probe should be used in order that it may follow the channel without injuring the tissues; never use any force while probing at the seat of disease. The question here is what to do in this case; nature herself is trying to exsect the hip-joint; if the patient does not succumb from the long process of suppuration, we often get remarkable results from nature's treatment; in fact, there are some gentlemen to-day who claim that this is better than surgical treatment; I must confess that I differ from that doctrine. Here now is dead bone, and there is no hope for that man to get well until that bone is removed; now in the slow process of nature to remove that dead bone, there is a long travelling of pus through various roads which it must make for its exit; at the same time more or less of that pus will be absorbed by the system, resulting in anæmia and exhaustion. The patient informs me that while the sinuses are open and

there is a free discharge of pus, he feels much better and his general health improves; this is because the poison of the broken down tissue is not absorbed by the system, but when the openings become closed as they are apt to do for a short time, there is no escape for the pus, and hence it is returned to the system, and as a natural result constitutional disturbance ensues, followed by loss of appetite, with febrile movement, etc. This process may go on until all the diseased tissues have been thrown off, if the man can outlive the disease, but this can hardly be called the rule.

The question now arises as to the advisability of complete exsection of the bone, and the application of a drainage-tube to the wound. My own experience is that where the disease has gone on to caries of the bone, and where you have relieved the parts from reflex action, and yet the inflammation still goes on to destructive caries, that notwithstanding your extension and proper adjustment of the parts to give the patient ease, and afford him the benefit of the open air for the improvement of his general health; that notwithstanding the drains are placed in such a manner as to give free outlet to the pus; if, I say, in spite of all these precautions the carious degeneration still goes on, then your duty is promptly to remove the diseased tissues by an operation. If, on the other hand, the caries diminishes and the discharge from the sinuses becomes gradually less, under your precautionary measures, then you should be satisfied with your expectant treatment. In one case of hip-joint disease Dr. Spencer removed nine inches of the femur subperiosteally, and recovery commenced from the instant, which resulted in a shortening of the bone of only three inches, with a good movable joint. In this case by making pressure into the joint severe pain is induced, but there is a total absence of pain immediately that extension is applied.

I am very glad to find that this limb is dressed in a proper manner, extension being made from the thigh and not from the leg alone. To illustrate this point in regard to the proper mode of extension, I can do no better than relate an incident that occurred when visiting London for the first time: A child was brought to me suffering from hip disease and in much the same condition as this man, and upon whom extension had been applied *from below the knee*. I took the child in my arms in such a position as to immediately relieve the diseased surfaces from pressure, and upon the instant the expression of the child's face turned from that of pain, to relief and contentment. When I removed the strips of adhesive plaster from the leg, one of the gentlemen present checked me, and stated that they had been following out the method of extension by making traction below the knee by the use of the adhesive plaster and roller bandage; I informed the gentlemen present that the treat-

ment had been entirely wrong, and that instead of making traction upon the thigh, they had simply been making traction upon the ligaments of the knee-joint.

We now propose to dilate these various sinuses and ascertain the precise condition of the bone, as to whether we shall perform the operation of exsection. Mr. Anthony White was the first one to perform this operation, in 1821; you will find a full account of the case in Cooper's *Surgical Dictionary*. Dr. Bigelow, of Boston, performed the operation in 1852, the patient dying twelve days after. I performed the first successful operation in this country in 1854.

In making your incision, it is very important to take a point midway between the anterior superior spinous process of the ilium and the trochanter major; that will bring you just over the top of the acetabulum; you then take a firm, strong knife, and plunge directly down until the knife touches the bone; then draw your knife down to the top of the trochanter major; then curve it inward, making your incision from four to eight inches, according to the extent of the bone diseased. You must be sure and make your incision *through* the periosteum. You then take a curved, probe-pointed bistoury, and make an incision through the periosteum only, at right angles to your previous incision, and at a line with the trochanter minor; then, with the periosteal elevator, peel up the periosteum from the diseased bone until you come to the digital fossa, where the rotator muscles of the thigh are inserted; here it may be necessary to use your knife, to carefully cut them off from the bone itself. After having peeled off the periosteum in this manner, the limb is to be adducted, and the diseased bone removed by a chain or small thumb-saw. If you find that you have reached healthy bone, your object is accomplished; but if on the contrary, you find that there is yet diseased bone remaining below your section, it must be removed, perhaps necessitating a larger incision. It is, however, an absolute necessity that all dead bone be removed, to make the operation a success.

Sometimes by passing the finger into the rectum you can determine to a certain extent to what degree the caries of the acetabulum has progressed, and if the head of the bone be in its place. My assistant informs me that the internal periosteum points to great thickening of its substance. Here passing a probe into one of these sinuses, it passes in to the extent of eight inches, and I cannot say how much further it may go. Under these conditions, and discovering a large amount of pus and dead bone within the joint, exsection of the hip-joint has been determined upon.

The disease in this case being in the right thigh, it is necessary for me to stand on the left side of the patient. I shall make my incision connect these various sinuses, it being always advisable to

follow this method when feasible. I therefore, as you observe, press the knife down at the point indicated, until I reach the bone, and I now make my curved incision. A broad curved spatula is now placed in either side of the wound, to hold it open; and upon further examination, we find the periosteum to be very much thickened. I now take this probe-pointed bistoury, and make my incision through the periosteum, half encircling the femur at the point below the trochanter minor, and then taking this periosteal elevator, I endeavor to peel off the periosteum; remember, it is very necessary to leave as much of the periosteum as possible; and now reaching the digital fossa, we divide the rotator muscles. Having peeled off the periosteum, I now take this small thumb-saw, and make my section below the trochanters, and with the aid of these lion-forceps withdraw the head, neck, and trochanters of the femur *en masse*. The acetabulum I find to be necrosed, and completely perforated to the internal periosteum, this, however, being intact.

Now although I have removed nearly five inches of this man's femur, I find that the bone is diseased still further down. I therefore peel off the periosteum still lower and my assistant pushing the shaft of the femur upward toward the wound, bringing the bone more fully into view and thus enabling me to remove the necrosed portion with greater facility, I find it necessary to remove another inch of the shaft in this case; this being done, I remove carefully as much as possible of the dead bone from the acetabulum and portion of the pubes which I find is also necrosed; the latter, however, is a somewhat difficult matter owing to the close proximity of the femoral artery to the diseased structures. The wound is now thoroughly washed out with a carbolyzed solution of a strength of one to forty. The operation itself is very simple but the after-treatment is extremely important, the whole secret of your success depends upon this. My assistant now carefully holds the diseased limb for fear of injuring the artery while the patient is placed in the wire cuirass, this being a wire cradle made to fit the patient with movable foot-pieces by which your extension can be maintained. I now fill the wound with Peruvian balsam, manipulating it in such a manner that it penetrates to all parts of the cavity in every possible direction. You now observe that I take this piece of oakum which is also saturated with the balsam, and carefully pack the wound in order to maintain the original shape of the periosteum, and thus as new bone is formed, it will be of serviceable thickness and strength. I now insert the drainage-tube, and put in a suture at the upper and lower portion of the wound, and endeavor to secure union of these portions of the incision by union by first intention.

You observe that as the patient lies in the cuirass, the anus is directly over the opening pos-

teriorily, thus allowing of free evacuations without soiling the instrument. The whole secret is to secure the sound limb as a means of counter-extension; first fastening the sound limb to the leg-piece with a roller bandage, commencing at the foot, and as you reach the knee, place a folded newspaper over it to prevent flexion; then passing your bandage around the thigh, and as you reach the perineum, bring your bandage from the perineum over the handle of the instrument at the side, by which means your counter-extension is secured. Having now fastened the sound limb in this manner, we apply our extension straps of adhesive plaster to the diseased limb, making the extension from the thigh and never from the leg alone in these diseases of the hip-joint; these straps, you observe, are secured in the ordinary manner with the roller bandage; and the foot is now secured to the right foot-piece of the instrument, and by means of this screw at the bottom the requisite extension is made. Having effected this, we now fasten the limb to the instrument with a roller bandage, carefully padding the inequalities of the limb in order to obtain equable pressure at all points. I now moisten the wound with carbolyzed oil, and cover it with carbolyzed cotton and the usual antiseptic dressing; securing the whole with a broad roller. This dressing can be left on for twenty-four, forty-eight, or sometimes ninety-six hours, or until such time as moisture shows itself upon the outside of it. You will also notice that I pass one or two turns of the roller over the abdomen, and thus secure perfect immobility of the parts.

Four months afterwards the patient was again brought before the class. During the intervening time since you last saw him, Dr. Keyes, in whose ward he was placed, found it necessary to make another incision, and remove further portions of necrosed bone to the extent of about another inch of the femur. At the time I performed the operation I feared such might be the case, but as the periosteum was very thin, and firmly adherent to the shaft lower down, and the diseased portion was so extremely small in amount and in the centre of the shaft, I was in hopes Nature would have eliminated that portion without further necrosis. This fact shows how absolutely necessary it is to remove all necrosed bone when operating. There are, however, some cases in which this may, perhaps, be impossible. We find that we now have a shortening of the limb to the extent of almost four inches. My impression is that, had the extension been properly adjusted, the shortening would not have been so great.

I now intend to apply the long hip splint, in order that the man can go out of doors and secure the benefit of the fresh air. You will notice that the sinuses are yet open, the lower ones discharging slightly, but the upper one has almost ceased, but a few drops of pus passing daily. The wound

itself is entirely closed. Now having applied the long splint, I commence passive motion at the joint, in order that I may create a new joint. With the assistance of his crutches, the leg being maintained in the desired position by the proper application of the splint, he can now walk around and secure the benefit of the fresh air, in the meantime nourishing him well with a generous diet in order to build up his general constitution. The disease in time becoming entirely eradicated, the length of the right limb can be equalized by the application of the high shoe.

TALIPES EQUINO-VARUS — ARTHRITIS —HYDRORACHIS.

CLINIC BY D. HAYES AGNEW, M.D.

This child presents the deformity known as club-foot; it is congenital, and is of the particular form which is described as equino-varus. The extensor and peroneal muscles are paralyzed, and the foot is therefore given over to the power of their opponents. The heel is slightly raised by the calf muscles; the tibialis anticus draws the inner border of the foot upward, while the tibialis posticus and the flexor longus digitorum twist the anterior two-thirds of the foot inward. The child, therefore, if he were allowed to grow up in this condition, would have to walk upon the outer edge of the foot; indeed, some cases progress so far that patients have been found walking upon the dorsum of the foot and outer side of the ankle.

The relaxation of the paralyzed muscles produces distortion, the ligaments elongate, and we often find displacement of the bones, with decided changes in their articulating surfaces. The different parts act at a great disadvantage, and their functions are materially interfered with. As a consequence, periostitis or synovitis may ensue, associated with great pain.

Although mechanical treatment and the use of electricity in many instances may be sufficient, the treatment to be adopted in this case is to cut the tendons of those muscles which keep the foot in its unnatural position. This child also has phimosis; but, although that condition will account for a great many disturbances, I do not consider that in this case it has any significance.

I find that the tendo-Achillis is flattened out like a ribbon. I make the parts tense, and draw the integument aside, so that the incision through the skin and that through the tendon shall not correspond, taking care to avoid the posterior tibial artery by passing the blade of the tenotome flatwise beneath the tendon throughout its entire breadth; then I turn its edge upward, when, with a slightly sawing motion, the tendon is completely severed.

The knife is withdrawn in the same manner in which it entered, and I instantly cover the wound with my finger to prevent the access of air, and apply a small piece of adhesive plaster.

The foot must now be forcibly placed in a correct position, and often it is necessary to use a good deal of power. Unless you are dealing with a case of acquired deformity with ankylosis from a pre-existing disease of the joint, it is best to place the foot in a proper position *at once*. You notice that, in order to prevent excoriation, I place a strip of lint with some benzoated oxide of zinc ointment over the ankle and along the side of the foot. Then I apply a roller-bandage, which ought not to exceed two inches in breadth, so as to hold the foot firmly.

I now apply this modification of Scarpa's shoe, which is provided with two screws, so that, by means of a key, not only flexion and extension but also abduction and adduction can be made. The apparatus extends above the knee so as to obtain leverage: it must hold the heel down and carry the foot out. The child's heel must rest upon the heel of the shoe. I have put into it a little cotton to prevent undue pressure. Everything depends upon getting the foot into a proper position, otherwise you will fail to effect a cure.

To-morrow morning the shoe and the bandage will be removed and the limb will be vigorously rubbed with alcohol. The dressings and the shoe will be re-applied, and this process of rubbing and motion will be carried out persistently. Faradization will often aid in the restoration of muscular power. Always use mild currents, and never for a longer time than four or five minutes every day. The patient will have to wear this shoe for one, two, or, possibly, three years; until the peroneal muscles have acquired the power of contractility it will not be safe for him to lay it aside.

ARTHRITIS OF THE ANKLE.

This boy has been brought to us with disease of the ankle-joint. When I first attempted to examine him a few moments ago, the resistance was so great that I could not form a satisfactory judgment, so I have had him etherized.

In comparing the two ankles, notice first the normal one, its prominent malleoli and the concavities below and behind. You observe that the diseased ankle is larger; the depressions on each side of the tendo-Achillis and behind the malleoli have been obliterated, owing to the softening of the texture of the ligaments and from an effusion into the extra-articular fibrous tissue. The leg itself is wasted and the foot is held in extension. In arthritis of any joint, the affected member always assumes that position which will ensure the most complete relaxation of the joint-tissues. The muscles are rigid, and are constantly on guard to hold the joint-surfaces in the relation most favora-

ble for comfort. Any interference with this position, whether by relaxation of the muscles during sleep or by forcible flexion or extension, makes the patient cry out with pain. The sudden starts that are so often seen in this disease are the result of involuntary contraction of the muscles as pain summons them at once to their duty. A good example of this involuntary muscular tension, and one of great diagnostic value, is seen in hip-joint disease.

Now that the muscles are perfectly relaxed by the anæsthetic, I can move the joint freely, but not without distinct grating of the opposing surfaces.

What shall we do for him? We must put the joint at perfect rest, and must remove all undue pressure upon the articulation. How shall we do this? First we place the foot at a right angle with the leg, and then apply a nicely-fitting flannel roller bandage as far as the knee. Having thus protected the skin, we apply a plaster-of-Paris bandage until the foot is firmly encased from the toes almost to the knee. The sound foot will be supplied with a high-soled shoe, and when the plaster is hard we will allow the patient to go about on crutches; were he younger he would have to remain in bed and from time to time be carried about in the open air. As the swelling recedes it will be necessary to renew the splint or to pad and re-apply the old one, in order that the joint may be preserved immobile.

When abscesses complicate the case, you may cut openings in the splint through which the discharges may escape and through which the proper dressings may be applied. This dressing must be persisted in for several months, and great caution will be required in resuming the use of the limb.

Kneading and rubbing the muscles, the cold or warm douche, and gentle and cautious passive motion must be instituted at the proper time.

Constitutional treatment must not be neglected. In pale, delicate subjects give iron, changing its form from time to time. Cod-liver oil in small doses, and, when the appetite flags, quinine or tincture of cinchona, will be found valuable. Milk and eggs, animal broths and meats, should be freely given, and wine or some preparation of malt may be allowed. Such a treatment, conjoined with fresh air and sunshine, will doubtless in this case be rewarded by success.

When, however, an ankle-joint becomes disorganized by suppuration and caries, do not defer an operation too long. When the disease has progressed from the joint to the tarsus, you may be mortified to find that amputation is demanded, where, a few weeks before, an excision of the joint might have sufficed.

HYDRORACHIS.

This infant, three weeks old, has a swelling in

the posterior portion of the lumbar spine, which was there at birth. It is due to a deficiency in the posterior arches of the spinal column, permitting a protrusion of the membranes of the cord and spinal fluid. This condition is sometimes called *spina bifida*, but, as this term relates only to the deficiency of the arch, I prefer to use the other name.

The skin covering this tumor is reddened, attenuated, and fluctuation is readily obtained. Whenever the child cries the tension is slightly increased. Closely attached to the sac of the tumor is the spinal cord; the fluid has pushed it back. The fluid is cerebro-spinal or sub-arachnoid.

As a rule, these cases are not capable of being treated by any surgical measure. Occasionally we find the enlargement pedunculated, owing to the small size of the aperture through which the tumor emerged. Sometimes, also, the skin is of the natural color. These conditions constitute the most favorable cases for treatment.

When, however, the fluid presses the cord or its nerves, paralysis of the bladder, rectum, or lower extremities, or even convulsions, may be produced.

In favorable cases the arches may close spontaneously and a cure follow. Such a result occurred in a child that was under our observation in this clinic for a period of two years. The tumor diminished gradually and its neck contracted until it was reduced to the size of a small probe; nothing was left but a little mass of what appeared to be the redundant integument of an extinct sac. The mother was anxious for its removal, and, as the boy had grown strong and the case seemed to have been perfectly well for over a year, I consented to clip off this thread-like pedicle. Not long after this a serous fluid began to dribble from a hair-like opening. However, by passing a pin through its sides and by bringing the parts together with a figure-of-eight suture, the opening was successfully closed, and the child made a permanent recovery.

So long as the natural process of pedunculation is progressing, it is best to keep a close watch, but to abstain from any operative interference. It is only when the tumor enlarges and threatening symptoms arise that you are to resort to any operation.

One method of procedure is to apply to the pedicle an elastic cord so as to favor the isolation of the sac. Another plan is to use injections for its obliteration, just as we do in cases of hydrocele. For this purpose we have used successfully, in the case of another child, a solution consisting of fifteen grains of iodide of potassium and one grain of iodine to the ounce of distilled water.

Injections should, in my opinion, be confined to cases where pedunculation exists. In their employment the neck of the sac should be compressed, to prevent the iodine from entering the spinal canal. A delicate trocar is then introduced

within the sac, and its contents entirely removed and preserved at the temperature of the body. After injecting the sac and allowing the fluid to run out, the cerebro-spinal fluid first removed may be restored. The canula is then withdrawn, and the puncture in the skin covered with a strip of adhesive plaster. If the result be favorable, the inflammation will have closed the communication between the cavity of the sac and that of the spine, and thus effect a cure.

Such treatment, unfortunately, is not applicable in the case of the child before you. We can only advise the mother to keep it carefully shielded from harm and not to allow anything to rub or irritate the back. The treatment—for the present, at least—must be palliative.—*Med. Times.*

THE MANAGEMENT OF ABORTION.

In a paper published in the *St. Louis Courier of Medicine* for August, Dr. Walter Coles gives the following as his treatment, which we endorse :

“Let us suppose that we have been called to a case in which the embryo has just escaped during the third month and the secundines are retained. Under such circumstances there is generally considerable hemorrhage going on, and the first thing in order is to check it. Of course the most effectual and desirable method of so doing is to empty the uterus and cause it to contract. A teaspoonful of fluid extract of ergot is administered, and the accoucheur at once examines the uterus. If it be practicable by digital manipulation, or the aid of the forceps, to deliver the placenta, this is a fortunate circumstance which should be availed of on the spot. But if the os is too contracted to admit the finger, or even if patulous and the membranous placenta is so adherent as only to be detached in fragments, it is better not to disturb it for the time being, rather than resort to immediate and forcible extraction. We should, however, be equally far from pursuing a *passive* policy. The hemorrhage should be controlled by means of a tampon, aided by ergot, supplemented by a full dose of tinct. of opium—the latter being especially beneficial as a soothing stimulant after blood loss. A tampon ought always to be applied with the aid of a speculum, that of Sims being the best. There is a great deal in the method of tamponing ; it should be carefully packed over the os and around the cervix. The best material is old cotton muslin torn into strips ; I prefer to put it in dry. Sponge is of very little service as a tampon ; it absorbs the blood and permits it to flow through.

“In most cases thus managed, the physician will find on removal of the tampon twelve hours later that the secundines have either escaped entire, or else are presenting at the os, whence they may be readily removed by very slight manipulation.

But in case this cannot be done without violence, it would be proper to wash out the vagina and again tampon, with the expectation that under the excitation of the plug and the continued influence of ergot, the uterus will by its contractions detach and expel its contents. If at the end of twenty-four or thirty-six hours there is no indication of dilatation, it will be quite time enough to consider the propriety of artificial dilatation and extraction. If the internal os continues closed, it is pretty conclusive evidence that the placenta is still adherent and hence not extensively decomposed. Lusk recognizes this condition of the internal os as a valuable indication—a fact pointed out by Hunter. He remarks that ‘When decomposition has once set in, the os internum will, as a rule, allow the finger to pass into the uterus.’ Such being the case, we have less reason for being in a hurry when the uterus is closed than if the inner os were lax and the discharges offensive ; under the latter condition of things the practitioner should lose no time in emptying the uterus of all decomposing material, provided he can do so without inflicting too much violence on the organ itself. * * *

“We are assured by the advocates of immediate removal that this is very easy of accomplishment—a thing which the merest tyro may perform, but most of our leading obstetrical authorities entertain a different view of the difficulties and dangers involved. Playfair, while admitting the desirability of emptying the uterus when feasible, goes on to say : ‘Cases, however, are frequently met with in which any forcible attempt at removal would be likely to prove very hurtful, and in which it is better practice to control hemorrhage by the plug or sponge tent and wait until the placenta is detached, which it will generally be in a day or two at most.’ Barnes reiterates the same advice, and cautions us that ‘We must not persevere too pertinaciously in the attempt at removal lest we inflict injury upon the uterus.’ The same author, recognizing the fact that the placenta after abortion quickly undergoes retrograde changes whereby its adherence to the uterine wall is weakened, thereby facilitating its removal, remarks that ‘The consulting practitioner here occasionally reaps credit which is scarcely his due. He is called in perhaps on the third day, or later, when the adhesion of the decidua to the uterus is breaking down. He passes in his fingers and extracts at once ; but had he tried the day before he might have failed like the medical attendant in charge.’

“Whenever there is serious and persistent hemorrhage threatening to exhaust the patient, active interference is of course demanded. Or if there is an offensive discharge and an elevated temperature together with rigors, we have good reason to apprehend blood-poisoning from the absorption of putrefying elements within the uterus. Under such circumstances it would be proper to explore the

interior of this organ, dilatation being resorted to if necessary. For this purpose the tupelo tent is certainly far superior to the sponge or sea-tangle. It has all the dilating qualities of sponge, while it is cleaner and can be introduced more readily, even without a speculum if desired. It has also the advantage over the sea-tangle in that it can be procured in larger sizes and is less liable to slip out of position. Whenever full dilatation is required the tupelo is preferable to all other tents. The uterine cavity having been exposed, all fragments of secundines should be carefully dislodged with either the finger or curette, after the manner so well described by Lusk and Murd , and the organ washed out with some disinfectant fluid. Where there is a tendency to bleeding, tincture of iodine answers an excellent purpose, and is cleaner than perchloride or persulphate of iron as recommended by Barnes. Where the disintegrating fragments are small, repeated irrigation of the uterine cavity (the os being patulous) will generally suffice, as they usually melt down and come away with the discharges. It is not safe to scrape the uterine surface more than can be avoided, for fear of opening up fresh avenues by which septic materials may reach the system, since we know that nature interposes a bar to infection by glazing over denuded surfaces and closing gaping vessels. For this reason Lusk remarks that 'Fatal results are, however, rare, as decomposition is usually a late occurrence, setting in as a rule, only after protective granulations have formed upon the uterine mucous membrane and after the complete closure of the uterine sinuses.' "

CASE OF COEXISTENCE OF DIPHTHERIA AND TYPHOID FEVER.

Dr. G. E. Paget, F.R.S., Regius Professor of Physic in the University of Cambridge, describes the following case :—

"The recent illness of the Postmaster-General may add interest to the following case. The patient was Mrs. J. K., a married woman, about twenty eight years of age, living in Manor Street, Cambridge. Three days before her illness began, one of her children had died of diphtheria, two of them having been affected. Mr. Carter, who attended them, had no doubt as to the diagnosis. The children had sore-throat, and exudation upon it.

When I first saw Mrs. K. (on December 14th, 1861), she had been confined to her bed about a week. From Mr. Carter I learned that her illness had begun with sore-throat, and that there had been small white diphtheritic patches upon the throat. When I examined it, I could find none, nor any signs of diphtheria; but upon her abdomen were some of the rose-spots characteristic of typhoid fever; and at the base of her right lung,

to the extent of two or three inches, the percussion sound was dull; and small crepitation could be heard. She was feverish; her pulse was 130; her bowels loose. She was in the seventh month of pregnancy.

For six days she continued in much the same state, as an ordinary case of typhoid fever, with moderate pneumonic complications; her bowels loose; her pulse above 120; her tongue dryish; and a general condition requiring wine and brandy. During these six days, her throat remained free from diphtheritic appearances; but on the morning of December 20th it again became sore, and in the evening the uvula and soft palate were covered with a white exudation, the adjacent parts being bright red. Her pulse then became a little less frequent, falling to 116. Chlorate of potash was now prescribed in small frequent doses, and next day tincture of perchloride of iron. On December 28th, her urine contained albumen. The exudation, after its reappearance on December 20th, was seen from day to day; it had a diphtheritic character, and was very extensive. It was still present, though somewhat reduced in extent, on January 2nd. When I saw her on January 5th, it had been completely cleared off.

Early in January, she began to suffer much from retching and vomiting. She was troubled also with cough. The right lung was consolidated at its base, but to a small extent only. The vomiting so persisted from day to day as to bring her into great peril. On January 20th, the liquor amnii escaped. Active delirium now came on, and continued for upwards of twelve hours, when she suddenly aborted of a seven months' child, which lived half a day. The mother nearly died during the removal of the placenta, though scarcely any blood was lost. After labor was completed, the vomiting ceased, and she gradually recovered.

Mrs. K. had been nursed during her illness by her mother, Mrs. S., aged 58, who lived in the outskirts of Cambridge, in an isolated cottage within a large garden. On February 14th, 1862, she took to her bed with typhoid fever. She had the ordinary symptoms; the rose-spots, loose stools, etc. She went on favourably until March 13th, when, after sitting up near an open door, she had rigors, ushering in double pneumonia and hæmorrhage from the bowels. She died on March 24th.

The chief interest of Mrs. K.'s case is in the disappearance of the local signs of diphtheria, and their suspension for six days during the continuance of the typhoid fever, and then their reappearance and persistence for thirteen days or more. This appears to me a fact, not perhaps contrary to what might be expected, but at least worth notice. It differs from what was reported in the case of Mr. Fawcett."—*British Medical Journal*.

HÆMOSTATIC FORCEPS.

Under the name of Hæmostatic Forceps, Dr. Oscar H. Allis, Jefferson Medical College (*Col. and Clin. Record*), introduces to the medical profession an instrument that he has devised for the arrest of hemorrhage during operations. The instrument consists of two blades, under the command of a spring; one of the blades is needle-



pointed, and can be readily thrust beneath bleeding tissues, which done, the grasp of the hand is removed, and the bleeding vessels left under the control of the instrument. As an illustration of their use, we may take the removal of the mammary gland. In this operation we usually have no large vessels to tie, yet the bleeding from many small orifices is often so troublesome that the operator is embarrassed, while the patient is not infrequently reduced to a condition of critical prostration. To have an instrument that is simple of construction, easily managed, instantaneous in its action, and one that will be generally useful, is certainly a consideration of no small moment. Such an instrument he has found this to be. He has used them very generally for the last six months, in private and hospital work, and feels that once in the hands of the profession, they will not soon be set aside.

The delay in applying a ligature is often a great annoyance. The operator feels that "too much blood is being lost," and while some vessels are being controlled by compression, he secures slowly, one by one, the larger vessels. Just this condition of affairs may be easily and promptly met by these forceps. As each vessel spirts, an instrument point is thrust beneath it, and the spring secures it against further leakage. One by one may be put on, until the number of instruments is exhausted, when the ligature may be applied to each at leisure. Often the grasp of the instruments are such that if they are allowed to remain a few minutes, their removal will not be followed by hemorrhage.

He has used the instruments for some time, and, while he cannot recommend them for every emergency, still he has employed them under so many and diverse circumstances, that he feels that the variety now made will meet the wants of the general surgeon, as no instrument hitherto devised will do. Several varieties are made, one of which consists of two needle blades. This instrument has a more general application than any single instrument. Surgeons not infrequently find, in the course of an operation, that blood will well up

from a considerable area. To catch up a part with the tenaculum and tie does no good; what is needed is to embrace the whole in a compressing band. For just such emergencies this instrument is happily fitted. It is grasped, the needles made to separate, to straddle the bleeding spot, and the work is accomplished.

ANTIMONY IN SKIN DISEASES.—Dr. Morris, in the *Brit. Med. Journal*, gives some of the more important diseases in which he had used the drug, leaving a more complete and detailed account for another opportunity.

Eczema.—It is now several years since my colleague, Dr. Cheadle, pointed out to me the value of antimony in the treatment of the acute form of this disease. In the majority of the cases which have come under my care, its beneficial effect has been both marked and rapid. In the acute general eczema of adults, which usually commences somewhat suddenly by heat and burning on the flexor surfaces, and on other characteristic positions, and is soon followed by abundant exudation of clear fluid, and in the form known as eczema rubrum, I generally begin with four or five minims of the vinum antimoniales three times a day, increasing the dose gradually up to seven minims. After a few doses the exudation ceases, and the local irritation is much relieved; but, in order to prevent a relapse, it is necessary to continue the treatment until all traces of the eruption have disappeared. In acute eczema of children, the dose should be in proportion to the age of the child—half a minim or less up to six months, and one minim or less up to a year. As a rule, I have found both children and adults bear these quantities well, neither sickness nor diarrhœa being produced. In the case of aged persons, however, the dose should not exceed three or four minims to begin with, as diarrhœa may result from the administration of a greater amount.

In the subacute forms, both of children and adults, similar doses, but continued for a longer period, are necessary. In chronic eczema, especially when localised, the use of antimony is less often successful; but even in this troublesome form, it relieves the acute exacerbations, and is occasionally followed by cure when other methods of treatment have failed.

In eczema impetiginodes of children, I have noticed little benefit from the drug till the scabs have been removed, and formation of pus checked by local treatment. Simple impetigo contagiosa from a local cause is not included in this category.

In the various forms of so-called lichen that occur in children, I have found antimony in the previously mentioned doses of the greatest value in relieving the irritation—a feature in which it resembles arsenic.

Psoriasis.—Though, in the majority of cases of psoriasis, arsenic is to be preferred to antimony, I have elsewhere called attention to the fact that, in certain persons, arsenic not only fails to relieve, but even aggravates the disease. I have, in some of these cases, tried antimony, and have noticed in a few instances that improvement took place, while in others it seemed to have no effect.

I have been obliged to condense the facts in this paper into very brief space, but two points I wish especially to lay stress on; first, that tartar emetic—in doses of $\frac{1}{32}$ to $\frac{1}{16}$ of a grain, according to age—can not only be tolerated, but seems to have a decided tonic action; secondly that it proves useful in those acute forms of skin disease that are usually aggravated by arsenic.

TREATMENT OF TYPHOID.—A fair idea of the manner in which typhoid fever is treated in New York may be gathered from the routine of the different hospitals.

In the New York Hospital many patients are simply put on a milk diet, with the addition of a moderate amount of whiskey, and no other treatment is used. Peptonized milk instead of ordinary milk is thought to be of service. For high temperatures the body is sponged with equal parts of alcohol and water, and sometimes the fluid extract of eucalyptus is given in fifteen-minim doses. Quinine is not much used. Tympanites is treated with turpentine internally, and in stupes over the abdomen. Opium is given when there is hemorrhage from the bowels or excessive diarrhoea.

At St. Luke's Hospital the treatment is the same, except that quinine is sometimes employed to reduce the temperature, and ergotine hypodermically for intestinal hemorrhage. Either opium or chloral are used to control restlessness and sleeplessness.

At St. Francis' Hospital, if the cases are seen early in the disease, large doses of calomel are given, with the idea of aborting the disease. Quinine in large doses is given to most of the patients. The salicylate of soda or the benzoate of soda are given by some of the physicians throughout the disease. Cold water in any form, to reduce the temperature, is but very little used. A solution of the acetate of alumina is given to nearly all the patients to prevent or control the diarrhoea.

At St. Vincent's Hospital quinine in doses of two grains every two hours is given to control the temperature. Cold water is not employed. Opium is used with diarrhoea and intestinal hemorrhage.

At Mount Sinai Hospital quinine in large doses is given to nearly all the patients. Cold water is not much used, but sometimes the patients are sponged off.

At Bellevue Hospital the treatment varies in the different divisions.

In one division the peptonized milk is much

used. Quinine, in large doses, is given when the temperature reaches 103° , and sponging is also sometimes used. Opium, the bromides, and cold to the head are used for the restlessness.

In another division quinine in moderate doses is given to most of the patients. For temperatures over 103° sponging with cold water or the Kibbee cot and sprinkling with cold water are used. Opium is given when needed.

In another division carbolic acid *gt. j.* and tincture of iodine *gtt. ij.* every two hours are given early in the disease. Quinine in ten-grain doses every half hour is given to reduce the temperature. Sponging with cold water is sometimes used. Opium is employed for severe diarrhoea.

In another division occasional sponging, and whiskey and opium when required are the only treatment.

At the Roosevelt Hospital full bathing has been tried in many cases but now cold sponging is more used. Bismuth and pepsin are given to many of the patients.

In all the hospitals milk, either simple or peptonized, is the regular diet of the patients.—*Med. Record Nov. 17.*

EASY METHOD OF RHINOSCOPY.—The importance of visual inspection of the naso-pharynx and posterior nares in all local diseases cannot be questioned. Ordinarily such examinations are attended with various difficulties. Dr. Walsham (*Lancet*) describes a simple method of overcoming these difficulties, admitting, however, that a somewhat similar procedure has for years been practised by some American specialists: A piece of soft red rubber tubing, about one-eighth of an inch in diameter, is introduced into one nostril, and pushed very gently along the floor of the nose till it presents just below the soft palate. It is then gently seized with a forceps, drawn out through the mouth, and loosely tied across the upper lip to the end protruding from the nose, the elastic tube being stretched just sufficiently to loop upward and forward the soft palate, and draw it well away from the posterior wall of the pharynx. The looping of the palate on one side is often sufficient; but a better view is obtained by passing a tube through the other nostril also and looping up the soft palate of that side in the same way. The posterior nares and naso-pharynx can now be examined with the ordinary laryngoscopic mirror with the greatest facility. One hand only is required to hold and direct the mirror (the stem answering the purpose of a tongue-depressor), the other hand is consequently free to perform any manipulation or operation that may be required. The tubes serve as a good guide, as they can be followed in the mirror winding round the upper surface of the palate, and so into the respective cloacæ. The introduction of the tube causes hardly any discomfort or annoy-

ance to the patient. Care, however, should be taken in passing the tube to let it only just present below the soft palate, as otherwise, if it is pushed further, it may impinge upon the lower pharynx, and is then apt to produce a tickling sensation and desire to vomit. When the examination is finished, it is better to withdraw the tube through the mouth rather than through the nose, and when the nasal end is just about to drop into the pharynx to give it a sharp whisk forward. If it is withdrawn through the nose, the mouth end trails along the tongue, causing a tickling of its posterior part. In place of the red rubber tubes, the American surgeons preferred to use flat tapes or narrow bandages for tying up the palate. These have necessitated the use of various instruments for passing them, such as the Eustachian catheter, Bellocq's sound, etc. The advantages of the red rubber tubing are, that it is soft, non-irritating, and possesses just sufficient resistance to enable it to be passed through the nose by itself, thus dispensing altogether with the use of an instrument, the passage of which, as for instance in plugging the nares is, as is well known, a source of much discomfort and annoyance to the patient.—*Med. Record.*

DISAPPEARANCE OF CARDIAC MURMURS.—The following is a summary of Mr. Greves' article on the above subject in the *Medical News*:

Although murmurs are among the most constant of the physical signs of heart disease, still their presence does not necessarily indicate the existence of incurable lesions, nor their absence that such lesions are not present. In forming a correct diagnosis and prognosis of any case, therefore, too much reliance must not be placed on the presence or absence of murmurs, as is too frequently the case, but other signs and symptoms must receive careful examination and consideration, for often on them alone is it possible to found a correct diagnosis.

The presystolic murmur of mitral stenosis, the most typical of all murmurs, occasionally disappears, the lesion still remaining. Mitral regurgitant murmurs, when due to simple relaxation of the heart's muscle, and dilatation of its cavities and orifices, as in chlorosis and general febrile conditions, in most cases completely disappear under appropriate treatment.

Tricuspid regurgitation is occasionally a temporary condition, due to bronchitis, etc., and when the cause is removed, the condition is recovered from, as is indicated by the disappearance of the murmurs.

Aortic systolic murmurs, due to a permanent lesion at the aortic orifice, may undergo changes in their intensity, but never completely disappear.

Aortic diastolic murmurs, in certain extremely rare cases have been known to disappear. In these cases a systolic aortic bruit is always present,

which remains persistent, and thus indicates the existence of a lesion.

Pulmonary systolic murmurs are persistent when due to an organic lesion; but if non-organic, may disappear temporarily or permanently.

DIAGNOSTIC VALUE OF UTERINE HEMORRHAGE AFTER THE MENOPAUSE.—During the course of a late clinical lecture on malignant disease of the cervix uteri, Dr. T. Gaillard Thomas stated, as an axiom in gynecology, that if a woman who has normally ceased to menstruate begins to have uterine hemorrhage, always suspect carcinoma. Not infrequently you will see in the medical journals the reports of cases begun to menstruate regularly again; but such accounts are altogether deceptive, and, if these cases could be followed out, it would be found, with scarcely a single exception, that the uterine flow was merely the indication of the presence of malignant disease. In other words, there is absolutely no such thing as the return of the menses when a woman has once reached the normal menopause. Not long since a patient of mine in the Woman's Hospital, who is sixty years of age, began to have a flowing from the uterus, and, as there was no indication of any external disease, I applied the curette to the endometrium and drew out some pulpy masses, which I sent to a well-known microscopist for examination. The report that I got from him was that the growth was not malignant in any respect, but simply a form of polypus. I am perfectly sure, however, that the microscopist is wrong, and for this reason: in the uterus of a woman of sixty, polypi never develop. The organ at that age is completely atrophied. Sometimes in women who have passed the menopause you will find uterine tumors which have all the appearance of fibroids. They are not by any means fibroids, however, but sarcomata.—*New York Med. Journal*, September 1, 1883.

TREATMENT OF PUERPERAL CONVULSIONS BY HOT BATHS.—In a paper by Dr. Carl Brues, in the *Archiv für Gynäkologie*, is given an account of eleven cases of puerperal convulsions treated by diaphoresis produced by means of hot baths. Other means, as the inhalation of chloroform, and the administration of choral hydrate, were also employed. The convulsions set in at different periods during labor, and in the course of first day after delivery. In four cases they came on at the beginning of labor, in two after the first stage had lasted some time, in one during the second stage, and in four a few hours after delivery. One only of the eleven cases died. There was present in all the cases albuminuria, together with more or less oedema. The baths were employed after the convulsions set in, during and after labour. A case is also mentioned in which forty-five hot baths were given during pregnancy. The author believes that

the immediate danger to life in these cases is due to the diseased state of the blood—hydræmia—shown by the albumen and anasarca; and that the rational treatment of this condition consists in the production of a rapid change in the blood-state. This he believes is brought about by profuse sweating, which, he states, diminishes the quantity of albumen in the urine, and the œdema. The hot baths have occasioned no bad symptom in the author's practice; they have not brought on premature labour when used during pregnancy, nor have they occasioned hæmorrhage when employed soon after labour.—*Lancet*.

THE TREATMENT OF HAY-FEVER.—Mr. W. F. Phillips of St. Mary Bourne, Andover, writes:—

"It is just over five weeks since a lady placed herself under my care for the treatment of hay-fever, or summer catarrh—a very much better name. She had suffered severely for many years, and sometimes from the end of May to near the end of July with little or no intermission unless she kept indoors. Her mother, it is worthy of remark, was very sensitive to the odour of certain flowers, and was affected by some of them even to the extent of fainting. She was not subject, however, to summer catarrh.

Knowing how exceedingly unsatisfactory is the treatment recommended and practised for this disease, as is sufficiently evident from the recent communications to the *Journal* on the subject, I sought for rational indications that might guide me to the selection of a remedy. I thought of the neurosis that seems to underlie most cases of this kind, and to constitute the essential cause or predisposition on which the disease depends; of the characteristic symptoms of the malady; the injection of the conjunctiva, the hyperæmia and hyperæsthesia of the nasal cavities, the excessive secretion of tears and mucous; and then I bethought me of a drug whose physiological action might indicate the possession of the power to control such symptoms. Belladonna was the drug that suggested itself at once, and I determined to give it a trial, all the more hopefully because I remembered how strikingly useful on similar indications, and by a parity of reasoning, I had often found it in ordinary conjunctivitis and simple catarrh. I began with the following prescription: R—Succi belladonnæ, ℥ xxiv.; aquam ad ℥ iij.—M. A teaspoonful to be taken every hour till relief is obtained. The medicine was taken without the production of any undesirable effect, and with very marked advantage indeed—an advantage that became still more evident and unmistakable, both to the patient and myself, when the dose was increased from one minim to one and a quarter (half a drachm in three ounces). Once, too, when the eyelids were especially tender, the patient was advised to use the mixture as a lotion to the

affected parts, and this local application was found to be a most useful addition to the internal administration of the remedy. Repeatedly, when the symptoms of an attack had been allowed to begin, the patient found prompt relief after a few doses of the drug, the catarrhal affection disappearing first, and then the asthmatic; and on taking it regularly every day after the malady had been subdued, she has found to her delight that she can take her walks abroad through blooming grass and flowers without the least protection or precaution—a thing she had not been able to do for years before.

The patient, remembering no doubt the failure of past treatment, pronounces the remedy "a great success;" but, however satisfactory the case may be, it is, as far as I know, a solitary one, and therefore stands in need of confirmation and support."—*British Medical Journal*.

THE TREATMENT OF PELVIC PERITONITIS.—

Dr. Goodell, in a clinical lecture in the *Med. Times* on this disease gives the following:—"In the first place give as much morphia as is necessary to relieve the pain, if you choose a hypodermic injection of morphia at first, but I prefer the use of opium by the rectum. I never give less than one grain of the aqueous extract of opium. It is a very good plan to add belladonna by the rectum, but do not put it in the same suppository as the opium. Belladonna is very good for the urinary tenesmus, and it also has an effect in lessening the inflammation. You have to push the opium but cannot push the belladonna. I also give large doses of quinine, giving in bad cases ten grains every four hours until the patient is completely cinchonized and is deaf. I next put a large poultice of flaxseed or corn meal over the abdomen. If this is covered with rubber or a piece of brown paper greased with lard it will keep moist and warm for twelve or twenty-four hours, for the rubber or greased paper retains the heat, and the temperature in these cases is always elevated, running up to 103° F. or 104° F. in the evening, and down to 101° F. in the morning.

"After you have passed the brunt of the disease you must begin to use blisters. In this case the worst is passed, but her temperature is, I am sure, not under 100° F. I shall blister her. How shall we blister? Here is a woman who has strangury to a certain extent, and you do not wish to apply a blister that is going to increase the trouble. I always use the cantharidal collodion. I shall paint a blister in this instance three by four inches, putting on three or four layers, and then at once put over this a poultice. This is an almost painless way of raising a blister. I have never seen it produce strangury.

"Now, gentleman, in a case of frank inflammation, such as that produced by a sound, where there is

nothing of a concealed character, this treatment will subdue it, but if the peritonitis is produced by sponge tents you have a bad case to treat.

"I am sometimes called in consultation to a case of peritonitis by some of my students, and they tell me 'I am giving quinine just as you direct us. I am giving two grains every three or four hours.' That is nothing at all. You should never give less than five grains.

"You will find certain nervous symptoms present. The woman will be weak and trembling, ready to burst out crying. In such cases I very often give large doses of the bromides, from sixty to one hundred grains in the twenty-four hours.

"If you treat your cases in this heroic way, you will, in the great majority, cure them at the very beginning of the disease."

CANNABIS INDICA; A VALUABLE REMEDY IN MENORRHAGIA.—Mr. J. Brown, of Bacup, observes in the *British Med. Journal*: Indian hemp has been vaunted as an anodyne and hypnotic, having the good qualities of opium without its evils. Also in dysmenorrhœa and insomnia it has not proved of much benefit. The drug has almost invariably produced some marked physiological effect even in small doses. Text-books give the dose as ten minims and upwards, but five minims is the largest dose that should be given at first. If bought from a good house, the drug is not inert or unreliable. A drug having such marked physiological action ought to have a specific use as a therapeutic agent. Indian hemp has such specific use in menorrhagia—there is no medicine which has given such good results; for this reason, it ought to take the first place as a remedy in menorrhagia, then bromide of potassium and other drugs. The *modus operandi* I cannot explain, unless it be that it diverts a larger proportion of blood to the brain, and lessens the muscular force of the heart. A few doses are sufficient; the following is the prescription: *R* tincturæ cannabis indicæ ʒxxx; pulveris tragac. co. ʒj; spiritus chlorof. ʒj; aquam ad ʒij. One ounce every three hours. Four years ago I was called to see Mrs. W., aged 40, multipara. She had suffered from menorrhagia for several months. Her medical attendant had tried the ordinary remedies without success. Indian hemp was given as above. Its action was speedy and certain. Only one bottle was taken. She was afterwards treated for anæmia, due to loss of blood. Twelve months after this my patient sent for a bottle of the "green medicine." I learnt afterwards that she had sent this medicine to a lady friend, who had been unsuccessfully treated by another medical man for several months for the same complaint. It proved equally successful. The failures are so few, that I venture to call it a specific in menorrhagia. The drug deserves a trial. It may occasionally fail; this, however,

is not to be wondered at in a complaint due to so many different causes, and associated with anæmia and other cases of plethora. Robert Batho, M.D., M.R.C.P., Castletown, Isle of Man, writes in reference to the same subject: "Considerable experience of its employment in menorrhagia, more especially in India, has convinced me that it is, in that country at all events, one of the most reliable means at our disposal. I feel inclined to go further, and state that it is *par excellence* the remedy for that condition, which, unfortunately, is very frequent in India. I have ordered it, not once, but repeatedly, in such cases, and always with satisfactory results. The form used has been the tincture, and the dose ten to twenty minims, repeated once or twice in the twenty-four hours. It is so certain in its power of controlling menorrhagia, that it is a valuable aid to diagnosis in cases where it is uncertain whether an early abortion may or may not have occurred. Over the hæmorrhage attending the latter condition, it appears to exercise but little force. I can recall one case in my practice in India, where my patient had lost profusely at each period for years, until the tincture was ordered; subsequently, by commencing its use, as a matter of routine, at the commencement of each flow, the amount was reduced to the ordinary limits, with corresponding benefit to the general health. Neither in this, nor in any other instance in which I prescribed the drug, were any disagreeable physiological effects observed. I could say a few words in its favor, as to its action in allaying irritative cough, but I prefer confining myself to a point on which experience has left me no room for doubt."

OBTURATOR HERNIA.—Very interesting statistics on this rare affection are to be found in a pamphlet on *Hernia* by Dr. B. Schmidt, published in 1882 as part of Pitha and Billroth's well-known series. The cases where obturator hernia has been diagnosed during life are reduced to twenty-five; of these, seventeen were subjected to operation, eight were relieved by taxis, but only five altogether were saved by the two methods of treatment. Dr. Hasselwander of Hausbam, in Bavaria, records in the *Aerztliches Intelligenzblatt* a successful case of operation for strangulated obturator hernia. The patient, a countrywoman, aged 65, had suffered for three days from colicky pains, constipation, and flatulence. On two occasions, she had been seized with vomiting. Her appetite was bad, and she felt pain in the left foot. When first examined, her face shewed an anxious expression, her tongue was furred, her body emaciated, and her urine was highly albuminous. The abdomen was distended with flatus. No hernia could at first be detected. There were itching sensations in the left thigh, and numbness in the entire extremity. On closer examination, the depression, plainly marked on the right side, over the adductor longus in Scarpa's

triangle, was almost effaced on the left, where the same region was painful on pressure. On deep palpation, an indistinctly circumscribed hard smooth swelling was found on the inner side of the femoral vessels, over the adductor longus. On vaginal examination, fulness could be detected within the left side of the pelvis. Partial reduction was effected; but the symptoms became very serious a few days later, so that an operation at length had to be performed. The adductor longus was laid bare by an incision extending from below the pubes for three inches along the line of its outer border. That muscle was then cleared of the cellular tissue lying in its anterior aspect, and drawn inwards. The fibres of the middle part of the pectineus were divided, and a well-circumscribed swelling was in this manner exposed. The existence of hernia being now certain, the entire incision was enlarged, upon which very troublesome venous hæmorrhage occurred, and it proved difficult to control throughout the remainder of the operation. The external pudic arteries were drawn aside. The swelling was about the size of a pigeon's egg, and very tense; but it fluctuated slightly on pressure. Its surface was of a purple colour. Some strong adhesions were separated by the finger. By the aid of blunt instruments used with great precaution, the sac of the hernia was opened; its outer layer was aponeurotic; its inner coat consisted of a thick œdematous tissue, easily lacerated. There was no fluid in the sac, and the intestine lay immediately against its inner wall. On widening the incision in the sac by laceration till it became of a sufficient width, the intestine was found to be deeply congested and very tense. The finger was then passed into the neck of the sac, very sharply constricted by the border of the obturator foramen and the ligamentous tissue in the neighborhood of that region. Incisions were made in the inner and lower borders of the neck of the sac, by means of a straight probe-pointed bistoury. The intestine was then carefully replaced. Only the end of the little finger could be passed into the foramen. The venous hæmorrhage, the depth of the incision, and the lateness of the hour at which the operation was performed, apparently without the aid of any artificial illumination, made the operation very difficult. The wound was covered with an antiseptic plug. The patient passed a motion in the night, and was henceforth relieved from all intestinal troubles, though convalescence was prolonged through suppuration of the wound, the result of the damage done to the cellular tissue in Scarpa's triangle, and its extensive infiltration with venous blood. The patient, at the end of six weeks, was completely restored to health.—*Brit. Med. Journal*.

PAPILLOMA OF THE BLADDER.—A case is described by Rauschenbusch of a growth occurring in a man æt. 43, which was removed by operation.

The patient had been suffering from bleeding from the uræthra and cystitis for about a year, and when in the hospital he often passed bits of a villous tumor with his water, the dendritic character of which could be easily determined by floating them out in water. The tumor could be felt at the base of the bladder, by introducing the hand into the rectum whilst a catheter was in the bladder. Median lithotomy was performed, and the tumor, which was attached by a long stalk, was seized and twisted off, so as to avoid all danger of hemorrhage. Three or four weeks later the patient was free from all symptoms, and the wound healed. A year later there had been no return. The author draws attention to the fact that only seven cases of such operations are recorded, and in only five cases were they attended by success. It appears, too, that the favorite seat of these tumors is on the trigone, and near the orifices of the ureters, very rarely if ever at the top or sides of the bladder.—*Practitioner*, August, 1883.

CORROSIVE SUBLIMATE IN DIPHTHERIA.—Kaulich (*Bull. de la Soc. de Méd. de Gand*) *Med. Times*, has used in a number of cases corrosive sublimate, both locally and internally, in the treatment of diphtheria. He treats the exudation in the nose, the mouth and the throat by the applications of a solution of 1 in 2000. Among cases of infants that have had tracheotomy performed, the trachea is painted with the same solution four times, daily, or even every two hours. Inhalations were likewise ordered of .005 in 1000, fifteen minutes at a time, repeated every hour or less frequently, according to the case. Internally he gives to children one or two centigrammes, (gr. $\frac{1}{8}$ — $\frac{1}{4}$) daily in albumenized water containing a little cognac and sugar. Warm applications to the outside of the throat are likewise made.

A NEW FORM OF ASPIRATOR.—An aspirator has recently been devised by M. Creuzan, of Bordeaux, which is worked without piston or stop-cocks. It consists essentially of a large caoutchouc bulb, which, by means of a special arrangement of valves, may serve as an aspirator or an injector. A glass cylinder is attached to the bulb, so that the nature of the fluid may be readily determined. There is no possibility of air entering the cavity from which the fluid is to be removed, and the instrument possesses the further advantage that the operator requires no assistant, but can readily hold the trocar in position with one hand and the aspirator with the other. Any quantity of fluid may be removed by simply compressing the bulb without detaching the instrument from the needle.—*Med. Record*.

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

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TORONTO, DECEMBER, 1883.

The LANCET has the largest circulation of any Medical Journal in Canada.

VILIFYING THE PROFESSION.

The advertisement to which our correspondent calls attention in another column certainly exceeds anything of its kind in the unblushing way in which it seeks to exalt the merits of the advertisers, by the detraction of the regular profession. Between the regular medical practitioner and that large class of persons—difficult to define—who attempt to gain a livelihood by the public puffing of their wares, there has been declared a bitter and unceasing war. What will be its out-come, it is impossible to say. The advertisements of these people are a profitable source of income to the newspapers that insert them, and few will blame these papers for so doing, though doubtless all will praise the one or two which are notable exceptions to the rule.

That these advertisements have within the last few years, at all events on this side of the Atlantic, increased in their artful insinuations against the true and proper medical advisers of the community, is undeniable. But unfortunately their authors are too keen-witted to sail beyond the windy side of the land, and therefore do not come within the scope of libel. We may congratulate ourselves, however, on the fact that only the unenlightened and unsatisfactory patients are attracted; and even these, sooner or later, come back to the legitimate family physician. This, at all events, is true, that such action on the part of those who indulge in it, must in the end be suicidal, and nothing can prevail, in the long run, against the honest and modest efforts of the regular practitioner.

SANITARY CONVENTION.

The second Sanitary Convention of the Ontario Board of Health was held in London, Ont., on the 16th and 17th ult. There was a full attendance of members present, and others interested in sanitary science. In the absence of the Mayor, the members were welcomed to the city of London by Ald. Cowan, who expressed the hope that the convention would prove of great service in educating the public in sanitary matters. The opening address was delivered by Dr. Rae, of Oshawa, a member of the Ontario Board of Health. He pointed out the advantages of sanitary science in lengthening the term of human life and increasing the sum of human comfort. It was desired by this convention to elicit opinions and draw out facts bearing on sanitary science, so that we might learn how to keep the air of our houses and cities pure; to have an efficient system of sewerage; to check the spread of infection, and arrest the approach of preventable diseases.

Dr. Oldright, of Toronto, read a paper forwarded by Dr. Harding, of St. John, N.B., in which he spoke of the necessity of spreading information on sanitary matters. Physicians must, of course, always be the leaders of sanitary movements, but everybody can understand the general principles of sanitary science and apply them for the increase of human comfort and the prolongation of life. He strongly urged the necessity of ladies taking a part in promoting public health as well as the health of their families. Mr. Allen, of Chicago, referred to the labors in England of the Ladies' Sanitary Association, organized in 1855. Dr. E. G. Edwards, of London, spoke of the necessity of sanitary education in schools as the best method of reaching the public. Dr. Canniff, of Toronto, and others, approved of the teaching of hygiene in schools, and also of instructing the teachers. Mr. Saunders, of London, read an able paper on the "Water supply of London." After alluding to the impurities in the water of the wells, he said that the present public supply of water found in the extensive springs near the city, both in quantity and quality, never varied and never showed more than $15\frac{1}{2}$ grains of solid matter to the gallon. The springs are about 180 feet above Lake Huron, and nearly as high above all the surrounding lakes. The springs now used could supply two million

gallons per day, while additional springs could give one and a half millions more. The amount used is about one and a quarter millions daily. The system is growing in favor, and the water supply of London is now the best in the country.

In the evening session Judge Elliott, of London, read a paper on "Insanity in its relation to criminal responsibility." He adverted to the difficulty of defining insanity and of deciding when and where it began. Responsibility so far as a judge is allowed to define it, has nothing to do with the moral aspect of the case. The only question he has to consider is whether the man's condition is such that he should be punished for any crime committed. Even though a criminal had strong delusions on special subjects, it would always be considered whether these delusions had any connection with his conduct in any crime committed by him, and the facts in the case being brought out on a trial it would appear whether his insanity was sufficient to justify the opinion of his responsibility. The address was illustrated by cases from the law records, and was an able argument in proof of the wisdom of the legal doctrine of the criminal responsibility of alleged insane people. At the same time he admitted the full force of the view held in regard to the effect of training, education, disease, inherited tendencies, and poor living on both the moral, mental, and physical condition of the people, and these ought all to be considered in deciding on the responsibility in any given case. The subject of "Malaria" was introduced by Dr. Bray, of Chatham. He maintained that drainage was one of the most efficient remedies and recommended liberal Government grants for this purpose. Mr. J. K. Allen, of Chicago, editor of the *Sanitary News*, spoke of the province of the sanitary press, for which he claimed the support of all classes of the community, and anticipated great results from the labors of sanitarians through the press. Dr. Waugh, of London, presented a paper on "The London Floods" of last July and detailed the system adopted by the Volunteer Sanitary Committee, composed of London physicians and others. The people heartily supported the physicians, and the result was less sickness in that locality this summer and fall than ever before. Dr. Playter, of Ottawa, addressed the convention on the typhoid plant and its favorite soil, giving a description of the bacillus which constitutes the typhoid plant. He said that

human faecal matter was its favorite soil, the contagion being conveyed most frequently through water; the spores of the plant may also be carried long distances through the air, and this would account for the seemingly spontaneous origin of some cases. The proper disposal of excreta was absolutely necessary for the prevention of typhoid fever. Prof. Galbraith, of Toronto, read a paper on "Sewerage," in which he referred to the prevalence of disease to bad plumbing, and maintained that plumbing should be done under official inspection. Outside water closets stored with filth were an abomination and should be abolished. He also dwelt on the necessity for proper traps in the pipes, and ventilation by pipes running above the roofs of the houses. Dr. Bryce, of Toronto, referred to the absolute need of an active Board of Health in each locality, municipal boards of health, based on the same plan as the boards of education, with the same powers as to the expenditure of money, and having grants both from the Government and the Municipality. Dr. Arnott, of London, in an able paper showed how mill dams, locks, and obstructions to water courses, were fruitful sources of malaria by allowing decaying animal matter to accumulate, and thus infect the neighborhood with disease germs. Prof. Saunders, then alluded to the value of disinfectants which he said was in proportion to their power of oxidizing or deoxidizing organic matter of which chloride of lime was the cheapest and simplest, also free chlorine. Others were described and their advantages set forth. He said that one of the best modes of disinfecting a house was to smoke it with a wood fire, and then white-wash. Mr. Dearness, School Inspector, presented an able address on the hygienic condition of rural schools, in which he discussed school sites, ventilation and warming, water supply, sewerage, furniture, cleanliness, and school age. Resolutions were passed approving of the labors of the Provincial Board of Health, advocating the formation of local sanitary associations, and urging the Government to pass laws compelling the organization of local health officers, and requiring official inspection of all plumbing. A paper on "Control of contagious diseases" was presented from Dr. O. S. Wright, of Detroit. He advocated strict isolation of all cases of contagious diseases, and showed how infection was conveyed through clothing and articles of merchandize. He advocated placing

public place, schools, factories, laundries, and others, under close inspection. Dr. C. T. Campbell, of London, addressed the convention on the means of preventing the spread of infectious diseases in the schools," calling attention particularly to the different communicable diseases to which school children were liable. He alluded to the authority to exclude children suffering from or exposed to any contagious diseases, and submitted some rules for the guidance of school boards. He said that children residing within two hundred and fifty yards of any house where small-pox exists should be excluded from the schools until they produce a physician's certificate of effectual vaccination; and pupils afflicted with, or residing in any house where small-pox, scarlet fever, or diphtheria exists, within forty yards of such house, should be excluded until twenty days after the recovery of the patient. All pupils afflicted with measles, mumps, whooping cough, chicken-pox, or other eruptive disease of the scalp, should be excluded until complete recovery. A resolution was adopted recommending the Provincial Board of Health to prepare rules, based on those submitted by Dr. Campbell, and issue them to local school authorities for their adoption. Dr. Bryce, of Toronto, read a paper on consumption, which was very much appreciated, and the convention adjourned.

TORONTO SCHOOL BANQUET.

The annual banquets of the professors and students of the medical schools in this city were this year more than usually successful and the interest in them more fully sustained than on any previous occasion. Both entertainments were as usual conducted on strictly temperance principles—"Water! Water! everywhere, but not a drop to drink." The proceedings were enlivened by songs from the medical students' glee clubs and also by the sweet strains of music from a string band stationed in the gallery. Among the guests on these occasions were representative men from universities, colleges and sister institutions, Dominion and Provincial legislatures, the dignitaries of the church, the bar,

The tenth annual banquet of the Toronto School of Medicine was held in the Queen's Hotel on the 14th ult., and was a most successful gathering. A

large number of guests and friends of the school were present, besides many graduates and undergraduates.

The chairman, Dr. Patterson, assistant at the Toronto General Hospital, welcomed the guests, expressed gratification with the present position of the Toronto School, and said that the days of warfare with the police had passed, but if another encounter should occur, with the aid of the students from the Woman's Medical College they would expect to get the best of the fight. He also spoke of Toronto as a centre for medical education, and the advantages afforded by the General Hospital, the largest in the Dominion. Speaking of the establishment of the Woman's Medical College, he said that whatever might be the individual student's opinion regarding the advisability of women studying medicine, yet they were all glad that the women have a college of their own, and that the two sexes are not compelled to mingle in the same classrooms. He concluded by proposing the toast of "The Queen." The next toast was "The Universities and Colleges."

Hon. Edward Blake responded for Toronto University. He said he conceived the toast to mean a toast to higher education. Our community was one of the most democratic in the world. Nowhere was property more evenly divided, and nowhere had a people greater control of its own affairs. Therefore it was highly necessary that public instruction should be as wide as the franchise. This involved only an aristocracy of learning and virtue. It was of the last consequence that we should have in our midst institutions which would enable those who were ambitious to obtain advantages greater than could be derived from a high school education, to fit them to perform the high functions and duties expected from the citizens of a free country. Rev. Dr. Sutherland responded for Victoria College. These annual social events, he considered, bound the students closer to the institutions to which they belonged. He believed that the medical profession enjoyed the confidence of all right-thinking men. The advance in the knowledge of the healing art was made evident by the better sanitary regulations and the marked decrease in the death-rate. At the present day there was a tendency among medical men to become specialists, but although they might accomplish a great deal of

good in special lines, he thought it advisable that a physician should take a wider range of culture. Rev. Prof. Clark, in responding for Trinity University, referred to the general good qualities and the self-sacrificing spirit which characterized members of the medical profession.

The Chairman then proposed the toast of the "Dominion and Local Legislatures."

Hon. Alexander Mackenzie, who was received with great applause, was called upon to respond. He said it was the duty of the Legislature of every country to uplift the moral standard of that country, although there might be differences of opinion as to the reforms necessary to effect that object. In medical science there was still a great deal to be done, diseases to be traced out, and the values of medicines to be determined. There was always opportunity to effect some good which would excite the admiration of those who came after us. He would not have the bad taste to discuss the political differences between himself and those "on the other side of the house," but although some might believe that the Legislature was all that it should be, he, himself, had a very strong opinion upon the subject. He would leave the young men present to make a diagnosis of the case, but it was only fair to tell them that whatever prescription they might prepare, he would consider it his duty to prepare a counter-irritant. H. E. Clarke, M.P.P., also responded to the toast.

The toast of "The Learned Professions" was next proposed. Archbishop Lynch briefly responded. He said he would not preach a sermon, but would give them a text, "Honor the medical man on account of necessity," and urged that it should be honored in every household. He spoke highly of the medical men of Toronto, and urged the students to follow in their footsteps. Rev. Dr. Castle said that all professions were related to each other, because they were all made necessary by sin. Sins against one's body necessitated the medical profession; sins against some one else's body made the legal profession a necessity; and sins against God had called forth the clerical profession. For all of these professions great preparation was necessary before they could be worthily entered. Men who would lead in society must keep in advance of society. Mayor Boswell and Mr. Bryant also replied to the toast. The other toasts proposed were "Sister Institutions," replied

to by Dr. Temple, for Trinity College; Mr. McInerney, for McGill University; Mr. Herald, for Queen's College; Mr. Mitchell, for the Western University, and Mr. Johnston, for the students of Trinity Medical School. "Our Faculty," responded to by Dr. McFarlane; "Graduates and the Graduating Class," responded to by Dr. Cuthbertson and Mr. McDowell; "The General Hospital," replied to by Dr. O'Reilly; "The Freshman," by Mr. Leeming, and "The Ladies," responded to by Mr. Marty.

TRINITY SCHOOL BANQUET.

The seventh annual banquet of Trinity Medical College was also held in the Queen's Hotel on the 22nd ult., and was successful in the highest degree, both in point of the numerous and distinguished company, and the quality of the speeches delivered. The spacious dining-room was filled to overflowing and some of the undergraduates were compelled to dine in an adjacent room. The chairman, Mr. George A. Bingham, in welcoming the guests and opening the proceedings, delivered a most able speech. He said that such occasions as this was one of the few bright spots that illumined the otherwise unvaried tedium of the medical student's life. He alluded in feeling terms to the absence by death of some that were with us a year ago, and who were rendered dear to us by the bonds of student association. Upon an occasion such as this it is well that all should for a time unbend. Let the merchant forget his day-book; let the professor allow no thoughts of his dreary class-room to enter here. Let the alderman banish from his mind perplexing doubts regarding the efficacy of the block-pavement and the honesty of electric-light companies. Let the worried statesman forget a little the conflicting calls of party and of people; let the journalist forget if he can, that his country's safety depends upon the length of his editorials. Let the lawyer for a few brief hours of pleasure dismiss from his mind all the infinite technicalities of Blackstone; let the physician allow his suffering patients a brief respite from the terrors of pill and cataplasm, even at the risk of their too rapid recovery in his absence; finally, let the poor medical student banish from his mind the horrors of the class-room and the nightmare of examinations; let him forget that existence is a tripod and caloric

omnipotent. But he must not detain them, for there were better things to come and time was on the wing. He was reminded of the latter by the assemblage before him. Yonder, he saw him, a freshman, his joyous soul filled with high hopes and ardent expectations of renown in that profession around which his vivid imagination has thrown glamour, to be dispelled perhaps in future years. A little further on he saw a primary man, a few of his earlier illusions perhaps dispelled, struggling manfully for an honorable position in his chosen profession. And now he saw him a would-be graduate, just about to throw aside his student's cap and bid farewell to the halls and class-room of his *alma mater*. So time rolls on; from the freshman's gown to the graduate's diploma is but a little way, a brief struggle, but it is among the brightest in his career, and preparatory to a high and ennobling profession—for to increase the happiness by alleviating the misery of our fellow-beings is surely a God-given vocation. It will be ours to stand by the bed of sickness, and, aided by nature's healing power, to restore health; and finally, when she is about to pay her last debt, to stand beside the bedside of death, and, hand in hand with the hand of God, soothe the final moments of the dying. We will be received into the sacred bosom of the family as confidant and friend. Ours will be secrets in the history of our patients, known only to God and ourselves. Fellow-students! let us be worthy of this confidence, and let us not prostitute the high honor of our profession to baser interests. He concluded by proposing the usual loyal toasts, which were duly honored.

His Honor the Lieut.-Governor, who received a cordial greeting, acknowledged the toast of "The Governor-General of Canada and Lieut.-Governor of Ontario." He dwelt briefly on the careers of Earl Dufferin and Lord Lorne in Canada, and predicted a successful term of office for Lord Lansdowne. In felicitous terms he referred to the entire absence of alcoholic beverages from the tables, remarking that, notwithstanding anything said about medical students outside, it was evident that while others preached, they practised temperance. He urged upon the students to give some attention to political as well as medical matters. Leading doctors had done so in the past. Dr. Rolph, in times gone by, was not only known as a leading medical man, but also as a prominent

figure in Ontario's political history. Dr. Tupper was another example of a medical man who, in the opinion of his political friends, had done some good for the Dominion. In conclusion he said that hostile though some critics might be on medical students, yet, taken at their best, they could not be approached. The toast of "The Army, Navy, and Volunteers" was spoken to by Captains Baker and Geddes. "The Dominion and Provincial Legislatures" was the next toast.

Dr. Beaty, Q.C., M.P., acknowledged the toast of "The Dominion Parliament." In his reply he said he could not well understand why there should be more than one medical school in Toronto. If the 1,600 medical men in Ontario and 400 students in Toronto to-day were united, they would have much greater influence. He also favored a parliament of medical men, in place of Dominion and Provincial medical associations—an œcumenical conference. Hon. T. W. Anglin also spoke to the toast. In a few sentences he dwelt on the important duties performed by a member of Parliament, who fulfilled an onerous task and was entitled to all the honor and respect due to a man who did his duty. Hon. A. S. Hardy replied for the Ontario Legislature. Referring to the suggestion as to the union of the medical schools, he said that the members of Trinity School might deem that an open question. The present Legislature of Ontario had not yet met. He knew the last was a good house; but he did not know what kind of a character to give to the present, but he would be better able to tell them next year. Something would depend on its hospital treatment. Mr. Badgerow, M.P.P., responded, and opposed the suggestion of a union of the medical schools, remarking that Trinity could not be expected to make the first approach. Ald. Clarke, M.P.P., also replied to the toast. The toast of "The Mayor and Corporation" was warmly received and responded to by Mayor Boswell and ex-Mayor McMurrich. The toast "Universities with which we are affiliated and sister institutions" was next on the programme.

Rev. Prof. Clark responded for Trinity College. He expressed his dissent from the suggestion for uniting the schools. There were enormous advantages in not having too large a number of students. Vice-Chancellor Mulock, M.P., responded for Toronto University. After some general remarks

on the prosperity of the Province, which he attributed to the intelligence of our people, he said that when the proper authorities were called upon to say whether it was necessary that further aid should be given to the University of Toronto, he hoped the discussion on the subject by those who might hold different views would be conducted in such a way as to leave behind it that good fraternal feeling which existed to-day. He was satisfied that the University of Toronto occupied a firm place in the affections of the people of Ontario, and he was sure no college or institution doing similar work had anything but the best wishes for its success. Rev. Dr. Sutherland replied for Victoria College in a most able speech. He said he hoped that if any of them ever entered politics they would be statesmen and not mere politicians, and drew a vivid contrast between the two classes. Dr. Geo. Wright responded for the Toronto School of Medicine, Mr. Graham for McGill University, Mr. Forin for Kingston Medical College, Mr. Gibson for the Western Medical College, Mr. Watham for the Toronto School of Medicine students, and Mr. Haslam for Trinity College arts students. Drs. Burns and Macdonald replied for "The College of Physicians and Surgeons of Ontario."

The toast of the evening, "Trinity Medical School, its Graduates, Undergraduates, and Literary Society," was warmly received and was responded to by Dr. Geikie, dean of the faculty. He referred to the presence of representatives from kindred bodies, and expressed gratification at the unity of feeling and sympathy at present existing among them. He knew well the school had a firm hold on the hearts of the students, and it was most gratifying to the faculty to feel that this grows stronger every day. Their work was lightened and brightened by knowing that the students, for the promotion of whose welfare throughout their entire professional life their work was undertaken, fully appreciated the efforts made in their behalf. The present position and future prospects of the medical school were all their warmest friends could wish. He referred to the establishment in Montreal of a medical faculty endowment fund, and hoped that some friends in Toronto or Ontario would come forward to aid the establishment of a similar fund. He expressed gratification at the high position to which many of the graduates had attained in all parts of the world.

Drs. Stark, of Hamilton, and Baines, of Toronto responded for the graduates, Students in the different years for the undergraduates, and Dr. Shear for the Literary Society.

"The Learned Professions" was responded by the American Consul, Mr. Howard, in a happy speech. "The Toronto General Hospital," by Dr. O'Reilly. "The Ladies," by Dr. Sheard, and "The Press," by Dr. Fulton. In responding to the toast of the press, Dr. Fulton took occasion to refer to the expediency of having one uniform standard of matriculation for all the professions and also for arts, and civil engineering. Let all come up to the same standard of preliminary education; let all start, as it were, on the same plan and then let each branch out in the direction of his future course of studies. He also alluded to the question of amalgamation of the schools, to which he was opposed so far as the didactic teaching and internal management were concerned, and reminded them that where amalgamation was greatly useful it was now being carried out, viz., in the clinical instruction at the Toronto General Hospital. There were six professors from each school constituting a Faculty of *twelve* teachers, actively engaged in delivering daily clinics to the joint classes of the two schools. He would now christen this Faculty, and proposed as a volunteer toast "The Toronto Polyclinic," which was enthusiastically received. "Mine Host of the Inn," and the singing of God Save the Queen, brought the proceedings to a close.

The annual banquet of the Kingston Medical School was also held on the 22nd. ult., and was a most successful affair. Representatives were present from the sister medical schools in Ontario and Quebec.

H. E. MANWARING, M. D., of St. George, died suddenly from paralysis, at the age of 71 years. He was born in Lynne, Connecticut, and in 1821 came to St. George, Canada, where he has since lived. He graduated in the University of New York State, in 1839, and obtained the Provincial license to practice in Canada, in 1842. From that time to the day of his death he was actively engaged in the practice of his profession, and enjoyed the confidence of a large section of the community, who will long retain his name green and fragrant in their memories.

WM. MCGILL, M.D., of Oshawa, died on the 9th ult., aged 77 years. Dr. McGill graduated in McGill College in 1848, and practised medicine for many years in Oshawa. He represented the County of Ontario for several years in the Parliament of the late Hon. John Sandfield Macdonald. He was also a member of the Ontario Medical Council from 1869 to 1872. Although a liberal in politics, he was not considered liberal enough, and was therefore set aside when the Blake-Mackenzie government came into power. At one time he had a very extensive practice, but of late years he was unequal to the task of a country practice. His loss will be deeply regretted by a large circle of friends.

EUG. H. TRUDEL, M.D., of Montreal, died on the 5th ult., at the age of 63 years. Graduating in McGill College in 1844, he soon after commenced practice in Montreal, where he eventually acquired a large clientele and was one of the oldest and most respected physicians in the city. He was Prof. of Midwifery in L'Ecole de Medicine, and for years one of the attending physicians to the Hotel Dieu. Although far from robust, he had been able to attend to his usual duties up to a short time before death, which occurred somewhat suddenly and unexpectedly. His courteous and affable manner, kind and generous disposition, won for him many warm friends who will long cherish his memory.

OBITUARIES.—Dr. J. Marion Sims, of New York, died on the 13th ult., at the age of 70 years. He was the first to successfully perform the operation of vesico-vaginal fistula, which he brought to perfection through the use of silver wire sutures and the speculum which bears his name. He founded the Women's Hospital, New York, with which he was connected for many years. He also wrote an excellent treatise on "Uterine Surgery." Since 1861 he lived much abroad, especially in Paris, where he acquired a lucrative practice. He was decorated by the French and Belgian Governments. During the Franco-Prussian war he rendered important services at the head of the Anglo-American Ambulance Corps.

The death is announced of Dr. Henry Bence Jones, F.R.S., one of the most prominent physicians in Great Britain, and author of a number of

medical works. He was accidentally shot in the ankle, and died from the effects. He was in his 69th year. The death of Prof. Depaul, of the Faculty of Medicine of Paris, is also announced in our foreign exchanges.

TRINITY COLLEGE CONVOCATION.—At the annual convocation, held on the 15th ult., the following gentlemen were admitted to degrees and standing in this University:—

M. D.—H. C. Wilson, F. S. Keele, D. McLeod.

M. D., C. M.—H. H. Graham, S. W. McConochie, F. Krauss, T. D. Meikle, H. R. Casgrain, B. H. Scott, A. Cameron.

Matriculants in Medicine.—R. M. Gordon, W. J. Stevenson, B. Hawke, T. Ovens, D. A. Kidd, M. D. Kester, O. G. Niemeier, A. E. Mackay, D. McEdwards, J. A. McLuy, W. F. Cole, O. R. Staples, W. A. Fish, F. Woodhull, J. Hamilton, J. A. Tuck, J. Hoover, A. E. Yellands, C. A. Toole, E. M. Cooke, G. B. Carbert, D. McLaughlin, G. Mackenzie, T. Philp, P. Wood, T. F. Campbell, H. C. Phillip, Wm. Giles, J. McLurg, J. Moffatt, A. Shaver, F. H. Brennan, W. F. Graham, J. Evans, G. Veitch, C. E. Stacey, N. Allen, L. W. Thompson, E. T. Luke, P. J. Durkin.

LAKE VIEW RETREAT.—This institution for the treatment of nervous invalids of the private class, is beautifully situated in Burlington, Vermont, overlooking Lake Champlain, and in full view of the Adirondack mountains. The building is a most substantial brick edifice, and the family plan is adopted in the care of inmates, giving them the advantages of a home, at the same time under the treatment of a physician and the supervision of trained attendants. The institution is under the management of Dr. J. M. Clarke, who has had many years experience in the treatment of this class of patients. Lake View Retreat is within four hours ride of Montreal.

"STRATFORD" HOSPITAL, BRANTFORD.—John H. Stratford, Esq., has offered to build a hospital in Brantford, at his own expense, at a cost of \$12,000, and deed it to the city. This most liberal donation was thankfully accepted by the city council and the work of construction will be immediately commenced. It is to be called the 'Stratford' Hospital.

CORONER.—Dr. W. McFarlane, of Almonte, has been appointed coroner for the Co. of Lanark.

ACTION FOR DAMAGES.—The New Brunswick Medical Council arrested Dr. Rogers, of the International Throat and Lung Institute, for practicing without a license from the provincial board. This peripatetic individual, it appears, holds British diplomas, and has brought an action against the Council for false arrest, laying the damages at \$20,000. Mr. Dalton McCarthy, of Toronto, has been retained to prosecute in conjunction with local counsel. If Dr. Rogers' advertising propensities and his association with those who persist in vilifying the profession, were made known to the proper authorities, his British diplomas, of which he boasts so much, would be immediately cancelled, and then where would "Sir Roger" be?

LIBERAL DONATION.—Mr. G. Stephen, of Montreal, has presented to the Hospital \$50,000 of first mortgage land grant bonds of the Canadian Pacific Railway Company, in trust, for the purpose of erecting a building to commemorate the memory of the late Dr. Campbell. We do not wish that any of our noted confreres in Toronto should die; but it would be very gratifying if some of our rich citizens would follow the example of Mr. Stephen, and grant a liberal donation to the Toronto Hospital, to perpetuate the memory of some of those who have long since departed, and whose names are equally worthy of commemoration.

APPOINTMENTS.—Dr. Alex. Davidson, of Toronto, has been appointed examiner in Medicine for the University of Trinity College, and Dr. Allan M. Baines, of Toronto, examiner in Medical Jurisprudence and Sanitary Science. Dr. McMurchy, of Perth, has been appointed medical officer for the Nipissing District of the C. P. R. Dr. J. B. Lawford (McGill) has been appointed House Surgeon to the Royal London Ophthalmic Hospital, Moorfields. He is the third Canadian who has held this office. His predecessors were Drs. Buller, Montreal, and Burnham, Toronto.

BRITISH DIPLOMAS.—Drs. Geo. Curruthers and C. J. Bowser (McGill), were admitted licentiates of the Royal College of Physicians, London, on the 25th of Oct. Dr. W. A. Shufelt (McGill), of Knowlton, Que., has successfully passed for the L. R. C. S., Edin. Dr. J. M. Cotton, (Toronto), was admitted a member of the Royal College of Surgeons, Eng., on the 13th ult.

REMOVAL.—Dr. Playter, formerly of this city, has removed to Ottawa. He carries with him our best wishes for his future success in his new field of labor.

Books and Pamphlets.

MANUEL DES MALADIES DES FEMMES. Leçons Cliniques, Professées par Lombe Atthill, Dublin. Ouvrage traduit sur la 6me édition Anglaise, par le Dr. J. P. Lavoie, Prof. à l'Université Laval, Quebec. Paris: Librairie H. Louwereyns.

The above is a French translation of the well-known work of Dr. Atthill, on diseases of women, by Dr. Lavoie, of Quebec, by permission of the author. His confreres in Canada are under the deepest obligations to Dr. Lavoie, for his most excellent translation of this valuable work. So far as we are capable of judging, the work of translation has been well and faithfully accomplished and reflects no small degree of credit upon the author. We congratulate our French confrères upon having a work so useful and practical as the one before us, translated into their own language, and we trust they will avail themselves of the work, and in so doing reward the author for his arduous labors.

THE PHYSICIAN'S VISITING LIST FOR 1884, by Lindsay & Blakiston, Philadelphia.

This old and well-known visiting list is again to hand and still maintains its position as one of the best, if not the best, list published. It is one of the smallest, most compact and complete works of the kind issued, and is in great and deserved favor with the profession. It is issued in different sizes, and in two editions, plain and interleaved.

Births, Marriages and Deaths.

At Cobourg, on the 14th ult., Dr. G. Herbert Burnham, of Toronto, to Frances Sarah, only daughter of Hon. Sidney Smith, formerly Postmaster-General of Canada.

In Toronto, on the 7th ult., Richard Hearn, M.D., to Miss Nellie French, of Toronto.

At Mount Forest, Ont., on the 6th Nov., Dr. S. R. Rogers, aged 26 years.

At Winnipeg, Man., on the 20th ult., Dr. De la Haye, late of Toronto, aged 40 years.

At Lucan, Ont., on the 12th ult., J. J. McIlhargy M.D., aged 26 years.

*** The charge for notices of Births, Marriages and Deaths is Fifty Cents, which should be forwarded in postage stamps with the communication.*

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Original Communications.

MANAGEMENT OF HIP-JOINT DISEASE.*

BY M. C. ATKINSON, M.D., BRISTOL, N. B.

I wish in this paper to bring before the meeting, the history and treatment of a few of the cases of hip-joint disease which have come under my care during the past eight months, and also to make a few remarks upon the diagnosis and treatment of the disease in its earliest stages:—

CASE I.—The patient was a boy in his 14th year. His family history was good. I saw him first on the 19th of October, 1882. He had then been suffering over a year from Potts' disease of the spine, and had angular curvature at about the sixth dorsal. The whole left lower extremity was paralyzed as to motion, with diminished sensibility also; he was constantly tortured with a burning pain in the foot and knee. The right lower extremity was very weak, as if from approaching paralysis, but he did not suffer any pain in it. Both feet were œdematous, the left more than the right. There was abnormal fulness about the left hip-joint. Suspecting disease of this joint, I made a most careful examination, and found that free motion of the joint in all directions, or pressure of the articular surfaces together, caused no pain. Pulse at this time 110, temperature 101° F.; appetite poor; nights restless.

Treatment.—Wyeth's beef iron and wine, pulv. ipecac. co. at bedtime, and inunction of ol. morrhue over the whole surface of the body, twice daily.

Oct. 24th.—Had improved in appetite and slept better. Applied Sayre's plaster of Paris jacket, suspending the patient in the usual way. The same general treatment continued, and half a

tablespoonful of ol. morrhue twice daily, to be increased as stomach could bear. Patient continued to improve in general health, a slight degree of motion returning to the left leg and foot, so that on November 19th he was able to flex or extend the foot on the leg and move the toes freely, but the burning pain continued in the knee and foot. I again examined the hip-joint, and found slight tenderness just posterior to the trochanter major.

Nov. 24th.—Detected a slight swelling on the anterior and external aspect of the thigh, about on a level with the insertion of the tensor vaginæ femoris, in which I got fluctuation; tenderness just posterior to the trochanter major became more marked, and though I could move the femur in all directions, and press the joint surfaces together without causing pain, I yet concluded that the patient suffered from hip-joint disease, and accordingly applied Buck's extension. This relieved the pain in the knee, but the vitality of the patient was so feeble that the apparatus had to be removed and sand-bags used on either side of the limb to keep it at rest. Abscess steadily increased, causing a good deal of pain; pulse and temperature kept up

Nov. 30th.—Appeared evident that the abscess would soon open. The usual symptoms of hip-joint disease now became apparent. I put the patient on quinine in addition to his regular treatment, and on December 1st I opened the abscess subcutaneously, an immense quantity of thin, shreddy pus escaping. I used as well as I could the antiseptic precautions minus the spray.

Dec. 4th.—Temperature 103½; pulse 128. Pain in head, frontal; loss of appetite; abscess discharging profusely.

Dec. 9.—On moving the limb I got distinct grating. I pointed out to the parents that I thought excision of the head of the femur offered the only chance for the patient's recovery. To this they would not consent. The patient lingered for some time, and died on the 1st of March.

The remarkable features of this case were the almost total absence of the usual symptoms of hip-joint disease, till after ulceration had taken place. Either the usual symptoms were masked by the paralysis or the disease came on and advanced with extreme rapidity after November 19th.

* Read before the N. B. Medical Society, July 18, 1883.

CASE II.—The patient was a delicate girl, aged 13 years, tall, but very slender. Family history of phthisis from her father's side. Saw her first on the 23rd of March, 1883. For the previous six weeks she had complained of weakness of the left leg, and inability to use it. The parents attributed it to a fall on the ice. On careful enquiry, I found that the patient had suffered slightly from this weakness before the fall on the ice. She had very little pain in the limb anywhere except in the knee, and occasional slight startings in her sleep. On examining the limb, I found it slightly adducted slight flattening of the nates, pain on pressure over the great trochanter, and over the psoas-iliac tendon; also pain on striking the sole of the foot. There was increased heat over the joint, and any attempt to flex the thigh upon the trunk produced acute pain—the whole pelvis moving with the femur. Pulse 104; temperature 100° F.

Treatment.—Ordered a mixture of quiniæ sulph. tr. ferri mur. and infusion of calumba with hydro-leine. Had a box made for the leg, extending from the ankle to the perineum, the outer side reaching to the axilla, and perforated. The patient was placed in bed, and the leg bandaged from the toes to the knee, and placed in the box which had been previously well padded with cotton batting. The upper surface of the leg was well covered with batting, and a bandage passed around the box to retain the limb. A bandage was also passed through the hole in the arm of the box and round the thorax. The object of the box was to prevent as much as possible, all motion of the hip-joint. The patient remained in bed and the box was kept on continuously for six weeks. I then removed it and examined the joint, when I found that I could produce flexion or extension with but little pain. The patient had not suffered from pain since the apparatus was applied. She had gained decidedly in flesh. The apparatus was re-applied and kept on for four weeks longer. It was then taken off. All symptoms of hip-joint disease had disappeared except that the limb was very feeble. There was free motion of the joint, in all directions, without pain. Ordered the patient to go about on crutches, but not to put much weight on the limb.

June 25th.—Saw the patient again, and her general health had improved remarkably. She was still unable to bear much weight on the affected

limb, but the joint was freely movable and painless.

CASE III.—Patient was a boy in his fifth year. Family history good; no history of injury. Saw him first on the 27th of March, 1883; he had suffered from diphtheria the previous October, but had fully recovered; was lame, but able to walk about; had a peculiar hitch in his walk quite characteristic of stiff or diseased hip-joint. Delicate-looking; temperature 100° F.; pulse 115. He had suffered from lameness for the past two months, which was steadily growing worse; appetite poor; suffered from pain on inner side of knee; increased heat over affected (left) joint; woke up with intense pain in joint at night; foot and knee slightly adducted; pain on pressure over trochanter major, in front of joint, and on striking the sole of the foot. In attempting to move the hip-joint, the pelvis moved with it, and this seemed greatly to disturb the patient; slight, but distinct flattening of the nates. I concluded, in this case as in Case II., that the patient suffered from incipient disease of the hip-joint, and adopted the same plan of treatment. The apparatus was applied on March 31st, and was kept on continuously for seven weeks, with the exception of an occasional removal to ascertain the condition of the joint. After that time the patient was allowed to go about on crutches. Saw the patient on July 1st; he had given up the crutches; the joint was freely movable, and he had perfectly recovered.

Remarks.—The point I want to emphasize particularly in connection with this subject is the *early diagnosis of the disease*. This is all-important. No slight limp in a child should be lightly passed over by the surgeon, or pressed into the already over-crowded "rheumatic" basket. Hip-joint disease should be suspected and carefully looked for. A rigid examination will generally explain any lameness, especially in the young. If we find no trouble in the ankle or knee joints, but pain on the inner side of the knee, pain on pressure over the trochanter major, over the psoas-iliac tendons increased heat over the joint; acute, or even slight pain on moving the joint or striking the sole of the foot, we will make no mistake in treating such a case as hip-joint disease. It is scarcely necessary to remark that an increase of pulse and temperature always occurs in this disease, and this should be looked for to confirm the diagnosis. Once hav-

ing diagnosed the disease, our great object should be, *rest to the joint*. Let the limb be put in its natural position, (the patient on his back), and kept then as nearly immovable as possible. If by using an apparatus simply to prevent mobility of the joint, the pain is unrelieved; some form of extension should be adopted. In the majority of cases, however, if seen early, no extension will be necessary. It seems to me that extension should be avoided if possible, and when adopted for the relief of hip-joint disease, the extension should be made from the lower part of the thigh; a constant dragging on the limb by a weight and pulley is scarcely compatible with physiological rest; moreover, it is liable, especially in young subjects, to produce diastasis, particularly when applied to the leg, as is usually the case. As to keeping the patient in bed, and the apparatus constantly applied, this is imperative. The parents always fear that the general health will suffer, the facts are, however, that the patient usually gains in health and strength.

Constitutional treatment should be attended to in the majority of cases—the patient should be built up by every means in our power. If the stomach will bear it, some form of cod-liver oil should be given; if not, and there is great wasting, inunction of the oil should be practised. Wyeth's beef iron and wine, and Parrish's chemical food are also excellent preparations for sustaining the strength of the patient.

I believe, that by the early diagnosis of this disease and its prompt treatment by rest, many of its terrible results will be avoided, and the withered and deformed limb and peculiar gait of the victim of hip-joint disease will become as rare as it is now common.

SOME POINTS IN THE TREATMENT OF ABORTION.*

BY A. T. CARSON, M.D., M.R.C.S.ENG., TORONTO.

MR. PRESIDENT AND GENTLEMEN,—I fear that some of you expect to hear an exhaustive paper, brilliant with quotations and bristling with authorities—these will be disappointed. I propose to give simply the result of my own individual experience and the rules which have guided me.

Looking back on the work of our predecessors, we wonder at the way in which the pendulum of practice has been swung from one extreme to the other. We know that at one time in the history of obstetrics the placenta, even at full time, was never removed, even if it took weeks to come away. In proposing that the afterbirth shall be at once removed in either natural labour or abortion, are we not ourselves going equally far in the opposite direction? When called to a case of abortion, the questions are: what have we to fear? what have we to do? The one question naturally hangs upon the other. Our fears are septicæmia and hæmorrhage.

Now with regard to the bugbear septicæmia, I desire to speak with all due respect—a respect caused not so much by its frequency as by its fearful results. As to its frequency, I fancy that we should see less of it if we were more careful to avoid all predisposing causes. We have all attended cases of delivery where the foetus was putrid and sickening; we have opened fæcal or other abscesses with a perfect stench; we have had psoas and other chronic abscesses and comminuted fractures without the slightest sign of septic poisoning; we may have hectic or irritative fever, but we do not fear septicæmia till we ourselves do something conducive to its arrival. I do not mean to say that septicæmia is impossible in these cases, but that it is so very rare that its fear does not influence our practice. If we were equally careful in cases of abortion, I believe we might reduce the danger of septicæmia to a minimum in that also. The walls of the vagina being constantly in close apposition, the contents of the uterus are preserved from all external atmospheric contaminating influences, and I hold that it is the duty of the attendant to preserve this state as long as possible. It is true disinfectants will help us much in this, but they cannot be relied on with absolute certainty, and more especially in country practice are not always available. In some districts where abortion seems to be common and people careless about it, it is astonishing how long cases are allowed to run on without assistance. A German professor, in a paper on this subject, regretted that his clients often waited for twelve or fourteen weeks before coming to him, yet not one word did he say of septicæmia. If septicæmia were a common result of mere retention of pla-

*Delivered before the Toronto Med. Society, on Dec. 13, '83.

centa, we should hear more of it in connection with such cases.

When called to a case of abortion, unless the case be one of great urgency, I make no vaginal examination whatever. I leave the uterine contents free from the slightest chance of contamination as long as possible. If the loss be free, I order a dose of ext. ergot and tr. ferrî every half hour or hour. If the loss be long continued, it is astonishing how well the iron enables it to be borne. With regard to the use of ergot, I am perfectly aware of the objections which have been raised against it, but do not consider them of the slightest moment. We know very well its effect in cases of ordinary midwifery, and there are no grounds for supposing that it has different effects at different months of gestation. I have often used it when the head was on the perineum and have never had it complicate a case with any form of retained placenta. A well known lecturer on midwifery informed me that, having used ergot subcutaneously at the end of the second stage over 2,000 times, he has never been able to trace any placental difficulty to its use. Besides, I fancy that the hemostatic action of ergot is not sufficiently appreciated. We know that if used freely during the first stage of labour, the child's life may be endangered. Why? It used to be said, from the violence of the induced pains; but this statement is scarcely tenable, when we see children born alive after natural labours quite as violent and as protracted. We are then driven to the belief that the child is in peril either from something toxic in the ergot itself, or else from interruption of the circulation in the placenta, caused either by the continuous contraction of the muscular tissue of the uterus mechanically compressing the blood-vessels without intermission, or by the contraction of the arteries themselves. I have never seen a case where ergot was used to this extent, but as I have always understood that if born alive at all the child speedily revives; it seems that the argument in support of the toxic effect is weakened by that fact, inasmuch as the mere supply of air would not at once remove the toxic agent from the blood. Possibly both causes are at work, but undoubtedly the bulk of evidence seems to me to point to the danger arising from interruption of the placental circulation—the very thing which in abortion we wish to produce.

And now as to the practical results. Dr. Mundé's paper in the *Obstetrical Journal*, advocating the immediate clearance of the uterus by curette and forceps in every case, is founded on 57 cases, of which 30 were consultations. I have had in charge at least two or three times this number in the last twenty years. Some time ago, in reply to a correspondent, *The Field* (London) stated that 3,000 recorded consecutive games of whist were not enough on which to found a new rule of play. If this number be not sufficient to fix a new rule of whist, how many carefully observed cases of disease would be necessary to lay down a fixed rule of practice for the scarcely less complex phenomena of the human economy? certainly more than were seen by either Dr. Mundé or me. I simply give my experience, to be taken for what it is worth towards that result. I have been called in to cases in consultation in which we were glad to plug or get the uterus emptied by any means in our power. I have had one case of typhus fever who aborted the day she died of the fever. With this exception, in my own practice, I have not once had a case of septicæmia or a patient's life in apparent danger from any cause whatever, and have never required to remove a placenta or plug. The uterus invariably cleared itself in a few days at furthest, and the hemorrhage was restrained within reasonable limits. Much of this apparent difference in practice doubtless arises from the different races and classes with which we have had to deal. My experience is chiefly derived from dispensary work in a robust, rural, Celtic district in the north of Ireland, and must of necessity be quite another affair from work among the wealthy classes of New York. We cannot put furs on the Hottentot and order the Laplander to go naked, and in like manner we cannot make a fixed rule of practice to apply to every clime and nation. Besides, the more eminent a practitioner is, the more likely is he to be called to an unusually large percentage of bad cases, and as it is stated that one in every six or seven pregnancies ends in abortion, it is evident that many have no professional assistance, unless it be that of the dispensary doctor, as in Ireland, where his services are available properly, free of expense, to fully half the entire population of the island.

There is an old proverb, that "children should not play with edged tools." Any instrument in the

uterus is an edged tool, and though our graduates are far from fools, yet it must be admitted that they are little better than children in the use of uterine instruments. It is one thing to have a man of Dr. Mundé's experience empty a uterus with a curette, and quite another to place that instrument in the hands of a student for the same purpose; and any one who will teach his class that they are at once to attack *every* case of abortion with finger, forceps, or curette, will incur a responsibility which, I for one, would be sorry to undertake.

REMOVAL OF A LARGE FATTY TUMOR.

BY J. W. MACDONALD, M.D., L.R.C.S.E.; LONDON-
DERRY, N. S.

(Medical Officer to the Steel Co. of Canada.)

Mrs. C., aged 45, came under my care, suffering from a large tumor on the back, over the situation of the last three dorsal vertebræ. It had been growing for eighteen years, and for the last two years had been suppurating. She suffered very much from the weight of the tumor, as well as from the intense pain which accompanied the supuration. The growth was pendulous, measuring three feet in circumference at its thickest part, and twenty-three inches at its neck. Over its surface were enlarged veins ramifying in every direction.

I decided to remove the tumor. The distended blood vessels threatening to be troublesome a tourniquet was applied to the neck of the growth, by passing the band of the instrument over two flat pieces of wood, so that the neck of the tumor was pressed between them. This controlled the hemorrhage very satisfactorily, and allowed me time to secure the arteries by torsion, until about half the dissection was completed, when it was necessary to remove the tourniquet, in order to get at the parts of the tumor which were more deeply attached. The bleeding was more profuse in this stage, but by proceeding cautiously, and twisting the arteries as soon as divided, the operation was completed without the loss of more than a pint of blood. The deep portion of the tumor was firmly attached to the muscles and aponeurosis of the back, and to the spinous processes of the

10th, 11th and 12th dorsal vertebræ. All bleeding being stopped the wound, which measured fourteen inches in length, was brought together by silver wire sutures and dressed with carbolic acid solution, 1 to 40.

The tumor weighed 26 pounds and was an ordinary lipoma. The suppurating part showed no symptoms of cancer. For the first few days the pulse rose to 112, it then fell to 80, and she progressed favorably. On the 11th day the pulse and temperature again rose, and the wound discharged large quantities of unhealthy pus. Five grain doses of quinine, and thorough drainage of the wound, remedied these evils, and a complete cure was the result.

RADICAL CURE OF HYDROCELE BY CARBOLIC ACID.*

BY J. M. JONAH, M.D., EASTPORT, ME.

The author of the paper commenced by giving an interesting history of the treatment of hydrocele, describing the various methods which have been in fashion for centuries past. He alluded to the use of iodine, which he considered uncertain, and which in his experience had been followed by unfavorable results. He had commenced the use of carbolic acid in 1882, and had employed it in the manner recommended some years ago by Dr. Levis of Philadelphia.

He then gave the history of several cases he had successfully treated. The first was a chronic case in a young man whose hydrocele had been tapped *thirty-eight* times, and once injected with iodine. He drew off eight ounces of straw-colored fluid, and injected into the sac seventy grains of crystallized carbolic acid dissolved in about ten per cent. of water. A sensation of warmth was experienced by the patient, but no pain. On the sixth day after the operation the patient resumed work, and there has been no return of the hydrocele since.

The second case was also chronic, the patient having been tapped previously about twenty times. In this case also there were no ill-effects produced, and the patient was going about on the fourth day. Other successful cases under this treatment were also briefly described.

* Abstract of Paper read before the N. B. Med. Society, July 18, 1883.

The method of treatment is then fully given, by quoting Dr. Levis' description, which is as follows : "For the purpose, crystallized carbolic acid is maintained in a liquid state by a five or ten per cent. addition of either water or glycerine. After the tapping of the sac, I inject the liquefied crystals of carbolic acid with a syringe having a nozzle sufficiently long and slender to reach entirely through the canula. The object of this special form of instrument is to place the injection entirely within the sac, without any reflow, which would irritate the skin of the scrotum, the fingers of the operator, and without the possibility of injecting it into the connective tissue between the skin and tunica vaginalis. Ninety grains is the maximum and thirty the minimum I have used. As soon as the scrotum is injected, it is freely manipulated by the fingers of the operator so as to diffuse the acid over the lining walls of the hydrocele. A sense of warmth is produced, which is quickly followed by a decided numbness, and the patient is at once able to walk about. I do not enforce rest until 24 hours, when intra-scrotal inflammation renders quietude agreeable or imperative. I have never been able to detect any toxic effects from the absorption of the acid, no general depression, no discoloration of the urine. I believe that the action of strong carbolic acid on surfaces secreting albuminous fluids is to seal them, and, as it were, to so shut them off from the system that absorption cannot readily take place. In a case of hydrocele complicated with a sarcomatous testicle, I had moderate suppuration."

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—The following case will, I think, be a curiosity to some of your readers.

Some years ago I was called to a woman, a farmer's wife, whom I found suffering from a large right inguinal hernia. After a good deal of trouble I succeeded in reducing it. She had been troubled with it for some years, and had been in the habit of wearing an ordinary truss. This of itself was a somewhat rare case. But a year or so after, she consulted me for some derangement, as she thought, connected with irregularity of the monthly change. I was somewhat confused by

her answers to some ordinary questions, which went to show she did not understand much about the subject. I then made a digital examination without any exposure, and was surprised to find the vagina a mere cul-de-sac of about two inches long. Telling her I thought likely some operation would be needed, I gave her a placebo, and told her to return in a week, and I would more carefully examine her, and be able to tell what would be required ; and, at any rate, before undertaking any operation we would consult some other physician. At the end of the week she returned, and on exposing the parts, as you may well think, I was surprised to find a penis about an inch long, with well marked glans, without any appearance of prepuce, occupying the position of the clitoris, but of only half the usual extent around, the upper face or half of the urethra extending all the way, and visible down towards the vagina. In the right labium was a well marked round and firm testicle, and in the left one, not so well marked, but still quite distinct, the urethra being hid away under the pubis, and the vagina, as I have said, about two inches or less in length. In other words, I found her to be a man with an extreme state of hypospadias, including not only the urethra but the whole extent of the scrotum, and the penis firmly adherent all the way, only about the inch mentioned.

One point worthy of note is the extreme hypospadias much greater than anything I have seen mentioned in the books. But the great curiosity is the fact that she passes as a woman, and has been married more than twenty years to a shrewd, intelligent farmer, who seems not to suspect the least thing out of the usual way. She has a strong masculine voice and general appearance, with considerable tendency to beard. I need hardly add she has no children.

M. B.

December, 1883.

THE TUBERCLE BACILLUS.

To the Editor of the CANADA LANCET.

SIR,—I send you the following lines, which you may think worth inserting :—"A saturated watery solution of carbolic acid, even though it acts as long as fifteen minutes, is not sufficient to arrest

the development of the tubercle bacilli."—*Braithwaite*, July 1883; p. 73.

What say you, Koch, can this be true?
(The very statement seems to chill us;)
Is there, then, nothing we can do
Against this terrible bacillus?

A molecule, brandishing fell darts,
Arm'd, in the air, to meet and kill us;
Or burrowing in our vital parts,
Oh dread, invincible bacillus!

Monster! in microscopic space,
Who doth with seeds of death instil us;
Hast thou no vulnerable place,
No heel like that of old Achilles?

Has science nought for such a foe,
(Just as new hope began to thrill us?)
Come! who will strike a mortal blow
And vanquish the renowned bacillus?

Yours, &c.,

THOMAS W. POOLE, M.D.

Lindsay, Nov., 1883.

Reports of Societies.

MICHIGAN STATE BOARD* OF HEALTH.

(Concerted action by State Boards of Health.)

There has been a growing conviction among leading sanitarians intrusted with the official execution of practical health measures, that while the work of the American Public Health Association is of inestimable value in promoting the interests of sanitary science and sanitary reform, there is a constantly increasing need for an annual conference of State and other health officials in regard to practical affairs of their every-day work, some part of which work cannot profitably be discussed in a public meeting consisting largely of persons not familiar with its details.

After due consideration, a meeting of representatives of State boards was held at Detroit, during the recent meeting of the American Public Health Association, at which, after discussion, it was decided to call a meeting of the secretaries or other representatives of all State boards of health, in Washington, during May, 1884, for the purposes mentioned, and with the view of organizing a section devoted to State Board work in the present Association, or the formation of a permanent separate organization especially adapted to the needs of State Boards of Health. Drs. Henry B. Baker,

of Michigan, and J. N. McCormack, of Kentucky, were appointed a committee to confer with and secure the co-operation of all the State Boards in fulfilling the object of the meeting, and Drs. C. W. Chamberlain, of Connecticut, J. E. Reeves, of West Virginia, and Stephen Smith, of New York, were appointed a committee on organization, to report at the meeting in May. The American Medical Association meets in Washington in May; and another reason for holding the meeting in Washington is, that the representatives of the State boards may also have an opportunity for conferring with the senators and representatives in Congress from their respective States, in regard to national sanitary legislation. It would seem that whenever the health authorities of all the States shall meet, discuss, and agree upon the course they will pursue with respect to yellow fever, cholera, smallpox, or any disease which endangers public health without regard to State lines or borders, and whenever all State Boards shall act in concert, considerable progress will have been made in solving the problem of what are the best methods for national action in regard to inter-state and maritime quarantine or inspection and disinfection, as well as in the practical control of epidemic diseases within the several States of this country.

ONTARIO BOARD OF HEALTH.

The third regular meeting of the Board was held in Toronto on Thursday, Nov. 29th, 1883, and two following days. After routine the Chairman made a number of verbal communications, and the Secretary presented his quarterly report of communications received and work done.

A communication was received from Mr. Nasmith, baker, Toronto, referring to the probable relations of continued periods of moist weather upon the consumption of bread and other articles of food.

Dr. Cassidy presented a report on the "Smoke Nuisance," and the report of the committee on School Hygiene was read and adopted.

It was moved by Dr. Cassidy, seconded by Dr. Covernton, "That in view of the agitation which is taking place regarding the pollution of Ashbridge's Bay, Toronto, by liquid manure from the cow-byres, the committee on the Disposal of Sewage be requested to report to the Board on that subject."—Carried.

The report of the committee on School Hygiene was again taken up and it was moved by Dr. Oldright, seconded by Dr. Rae, "That the Secretary be directed to transmit a copy of the report to the Minister of Education; and the Board would express the unanimous opinion that the minimum of air space for each child should be in no case less than 500 cubic feet; and that this small space should be permitted only where there are such efficient means of ventilation and heating as will change the contained air six times per hour, thus allowing 3,000 cubic feet of breathing air per hour to each child."—Carried.

A special report from the committee on the "cattle-byre nuisance," Toronto, was read and adopted. The report stated that there could be no difference of opinion amongst sanitarians as to the result that must ensue—that a condition must be produced highly prejudicial to health and comfort, and the committee considered that there was good ground of complaint. It had been suggested that the nuisance might be abated by pumping the sewage to a large tract of land some distance from the bay.

Moved by Dr. Oldright, seconded by Dr. Rae, "That Drs. Covernton, Cassidy, the Secretary and mover be a committee to make arrangements for holding a Sanitary Convention at Ottawa, and also for arranging for a course of lectures on sanitary subjects in Toronto, during the ensuing winter."—Carried.

The desirability of establishing relations with the British Association, which meets in Montreal next year, was then discussed. The report of the delegates to the Canadian Sanitary Association meeting at Kingston, was read by Dr. Yeomans and adopted.

The Finance committee presented a partial report, after which the Board adjourned.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.

The regular monthly meeting of the above society was held on the 30th of November, the president, Dr. Robillard, in the chair. Dr. Playter was elected a member.

Dr. Prevost communicated his experience with jequinity, recently recommended in the treatment of granular lids. It was specially serviceable in those cases of trachoma accompanied by pannus. A solution of eight beans in four ounces of cold

water is made, and to this four ounces of hot water are added. This is used as a wash, once a day, a small quantity being allowed to penetrate beneath the lids. Its action is that of an irritant; inflammation is caused, sometimes very severe; when this passes away the original trouble is greatly improved, if not quite cured. Dr. Robillard had also used it with success.

Dr. Powell read a paper upon "The Complications of Typhoid Fever," in which he dwelt upon the pyrexia and conditions affecting the respiratory, circulatory, digestive, nervous and glandular systems.

Dr. H. P. Wright agreed with Dr. Powell, that a continuous moderately high temperature was more serious than a very high temperature of short duration. He cited two cases in point that terminated fatally.

Dr. Prevost reviewed the history of the theory of baths. He had experimented with sponging—taking the temperature both before and after—without detecting any reduction. He believed that in the general treatment of fevers, too much attention was given to this symptom.

Dr. Malloch agreed with the last speaker. He placed little faith in the various drugs used to reduce high temperature, as he always found it rapidly rose again.

Dr. S. Wright gave quinine in five grain doses every three hours, and rarely had a temperature above 100° or 101°. Some patients could not stand the drug, brain symptoms being caused, but, as a rule, a slight reduction in the dose overcame the difficulty. He reported a case where forty grains a day had been given for three weeks.

Dr. Grant, Jr., exhibited a brain, showing a neoplasm pressing upon the right ascending frontal convolution. A report of the case was promised.

BRANT COUNTY MEDICAL ASSOCIATION.

The regular quarterly meeting of the above named society was held in Brantford on the 4th ult., Dr. Harris, the president, in the chair.

After routine, Dr. Griffin reported on behalf of the committee appointed at a previous meeting to take steps towards the establishment of a hospital, that on account of Mr. Stratford's liberal offer to the city, the work of the committee was now at an end.

Dr. Sinclair, Paris, presented notes of a very

important case in his practice, as also did Dr. Marquis, of Mount Pleasant. These papers each elicited considerable discussion, in which Drs. Griffin, Winskel and Fairchild took part.

A vote of thanks was tendered Drs. Sinclair and Marquis for their interesting papers, and after some routine business the society adjourned, to meet again in Brantford on the first Tuesday in March next.

Selected Articles.

THE IMPROVED CÆSAREAN OPERATION.

The disposition manifested to return to the old method of abdominal delivery in the management of labors in pelves extremely narrow in their measurements, had stimulated suggestions from many prominent quarters, with the object of increasing the safeguards and precautions against the ordinary dangers attendant upon it. These are proposed mainly in reference to the prevention of hemorrhage, the security of the wound of the uterus against gaping, the warding off of septic influences, and the insuring of the greatest promptitude consistent with the proper performance of the operation. The various recent suggestions in these directions are very admirably set forth in a series of papers just completed by Dr. Garrigues, of New York, in the *American Journal of Obstetrics*.

In connection with these points, it is interesting to notice an operation recently (March 5th) performed in the Maternity of the Woman's Hospital of this city by Dr. Anna E. Broomall, Professor of Obstetrics in the Woman's Medical College. The patient was a negress, aged 22, with a conjugata vera of $2\frac{7}{16}$ inches, and a very exaggerated inclination of the pelvis, which increased the obstruction. She had been twenty-four hours in hard labor before she came into the Hospital, and attempts at delivery had been made by long-continued and vigorous compression and traction with forceps. At the time of the operation by Dr. Broomall, her temperature was 102° and her pulse 180, with offensive discharge of blood and shreds of tissue; but as the foetal pulse was distinct, and the mother's condition not absolutely hopeless, the Cæsarean operation was adopted, as giving more chance to both lives than any other method. Craniotomy was inadmissible with the active signs of life in the child, and the Porro operation involved too much shock; and, moreover, her intelligent consent to be unsexed was not obtainable in her then condition. The operation was performed with full antiseptic precautions as to assistants, instruments, and at-

mosphere. The main important feature was the adoption of the principle of the Müller-Porro operation, viz., the turning out of the uterus from the abdominal cavity, keeping the edges of the incision closely pressed against the uterine wall, and before incising the uterus making constriction of the cervix to prevent hemorrhage. This plan, first suggested by Litzmann, of Kiel, has been carried out heretofore in a few cases only, and without success, by placing a constricting band around the cervix, either a wire loop, or, as urged by Garrigues, an Esmarch rubber tube tightened up until complete arrest of circulation is affected. Dr. Broomall, however modified this portion of the operation in having the *cervix grasped by the hand of an assistant* and securely compressed until the uterine wound was closed by sutures. The hand was applied with its palmar surface upon the lower anterior face of the uterus, with the thumb and fingers extended with the commissure looking downward, then slid rapidly down until the soft tissue of the cervix could be grasped in its embrace, the head being gently pressed upward till the cervical tissues were entirely isolated from it. The softness of the cervical walls rendered an efficient grasp quite easy, and the circulation was absolutely controlled, there being apparently not a drachm of blood lost from the incision in the uterus. The placenta was implanted anteriorly and had to be cut through, causing of course the loss of its contained blood. The advantage of this method of constriction was seen to be immense. First, there is great saving of time, and that too at a period of the operation when every moment tells upon the vitality of the foetus. The difficulty of passing a cord or ligature of any kind over and behind the uterine body, carrying it down between the womb and the edges of the incision—which have to be kept closely in contact to prevent the escape of the intestines—and the care necessary to prevent loops of intestine and portions of omentum being carried down and grasped by the ligature, contused and perhaps permanently injured by the rough constriction, constitutes one of the serious delays in the Porro operation; and the manipulation necessitated by it, disturbing the placental circulation, involves great danger to the child. With the manual grasp, the fingers being gently slid around the cervix from in front and kept close to the uterine wall, such precautions are unnecessary, and the whole constriction is done instantaneously. In Dr. Broomall's case, it was less than fifteen minutes from the time the peritoneal cavity was opened until the uterine wound was completely closed, and in ten minutes more the abdominal walls were closed also, making only twenty-five minutes in all that the abdomen was open. Second a very important gain by this procedure is in the diminished risk from injury of the uterine tissues or the broad ligament and its appendages by their grasp in the soft hand, with its well-regulated and intelligent press-

ure, in contrast with their constriction by any mere machine. The hand would not be wearied in so short a time, but if it should become so, it could easily be replaced by the other, with scarcely perceptible interval of grasp. After thorough cleansing of the cavity, the uterine wound was closed by fine silver wire sutures, passed at very short intervals from the internal surface of the uterus outward through the whole thickness of the wall, and returning similarly through the opposite side, so that the middle of the loop, instead of the twist, was upon the peritoneal edge of the wound, thus bringing the peritoneal surfaces closely together with a little inversion of the edge. The wires were cut pretty closely and the ends turned in between the edges of the incision towards the peritoneal surface. This method was continued until the lower end of the wound was so nearly reached that it was no longer practicable, when silk braid carbolized and waxed was substituted. The condition of the mother previously and at the time of the operation gave but little hope, if any, of her life, but though the case was fatal after thirty-six hours, the autopsy showed complete union of the uterine wound throughout, and the abdominal cavity free from any trace of blood. The uterine surface was free from inflammatory action, but the intestines in the upper part of the abdomen above the uterus, were largely agglutinated by lymph. The child lived thirty-two hours, and was found to have had a large clot beneath the membranes of the brain, with fracture of the right parietal bone from the compression at the pelvic brim early in the labor.

The advantages of this mode of constriction and the facility with which it can be performed, recommend the plan of Dr. Broomall as a very important advance in the improved Cæsarean operation. The objection urged by Carl Braun von Fernwald to the use of ligature on the ground of the head being sometimes impacted in the brim (a condition certainly extremely rare in a pelvis of two and one-half inches) would not be applicable to the manual constriction, as the hand with its palmar surface could efficiently compress the cervical tissues against the head itself, quietly raising it upward till it had cleared the brim, the cervix being stretched and thus easily and efficiently grasped.—*Med. News.*

IMMEDIATE TREATMENT OF FRACTURES BY PLASTER-OF-PARIS BANDAGE.

BY CHRISTOPHER HEATH, F.R.C.S.

The object of my paper is to point out that many other fractures besides those of the leg may be most conveniently and satisfactorily treated by plaster-of-Paris bandages or splints, though I prefer the former.

A late American surgeon and friend of mine, Dr. Cowling, of Louisville, published, shortly before his death, three years since, a little book entitled *Aphorisms on Fracture*, of great value from its shrewd common-sense, from which I will venture to make a few brief quotations.

"*Aphorism 38.*—Carved and manufactured splints generally fit nobody, and are to be rejected, as not only expensive, but damaging."

"*Aphorism 41.*—The application of the roller bandage immediately to the skin, whether as a protective or to prevent muscular spasm, has resulted in such disaster, that it is one of the curiosities of surgery how it could be repeated at this day. When cotton is placed *over* such a bandage, it forms an absurdity scarcely credible in a man of ordinary sense."

"*Aphorism 44.*—Continued extension and counter extension are, as a rule, not necessary to prevent shortening in fractures. This is best done by removing the causes which lead to muscular spasm; first by an early and as complete reposition of the fragments as possible; second, by the smooth application of cotton batting to the limb; third, by the equal pressure of a bandage extending from the distal end of the limb to a point beyond the joint above the fracture; fourth, by the accurate fitting of the splints or plastic material for support; fifth, by as little interference afterwards as possible."

Mr. Gamgee has for so long advocated in this country the advantages of fixation and compression in the treatment of fractures, that it may appear superfluous to go at all over the same ground again; but my object is to induce surgeons to have more faith in the early treatment of fractures by plaster-of-Paris than appears as yet at all general, and thus to save their patients and themselves an infinity of trouble.

Let me take, as a good example of the treatment, an ordinary case of fractured patella. Every one knows that the joint soon fills up with blood and synovia, which take many days for their absorption, but every one apparently does not know that, if the case be seen before effusion has occurred, it may be entirely prevented by wrapping the knee-joint up in cotton-wadding, and applying a plaster-of-Paris bandage firmly over all. I have treated many cases in this way with only a couple of days' confinement, and believe that I have in some cases got osseous union between the fragments, so firmly are they knit together.

But, if effusion have already taken place, it is easy to get rid of it, if coagulation of the blood have not already occurred, by the use of the aspirator; and, the wadding and plaster being at once applied, no further effusion takes place, and the patient begins to walk about with a stiff knee as soon as the plaster is dry.

Unless a fractured tibia be very much comminuted and bruised, I look upon plaster-of-Paris,

applied as soon as possible, as the ordinary treatment to be adopted; and certainly in Pott's fracture of the fibula, with or without fracture of the internal malleolus, nothing is so comfortable to the patient, or of so little trouble to the surgeon, as a boot of plaster properly applied, with the foot carefully held at a right angle to the leg.

In the fractured thighs of children, I believe better results can be got by the immediate application of plaster-of-Paris over cotton-wadding than by any other method—even than by Hamilton's double thigh-splint with cross-bar, which is very convenient. And here let me venture to controvert a part of one of Dr. Cowling's aphorisms and the routine teaching of most surgical works, viz., that the joints above and below a fractured bone should be included in any apparatus and kept quiet so long as the fracture is under treatment. If a fracture be close to a joint, and *a fortiori* if it involve the articulation, then of course its fixation is essential; but why, with a fracture in the middle of a long bone, we should insist upon crippling a patient by doing our best to give him two stiff joints, I fail to see. With imperfectly fitting splints, it may no doubt be desirable to fix approximately the neighbouring articulations in order to obviate movements which would disarrange the fracture; but how incomplete the fixation is, any one may see who will watch a case of fractured thigh treated with the long splint. To enclose joints unnecessarily with plaster-of-Paris, is to provide cases for the "bone setter;" and I should never include the knee or hip-joints in any ordinary case of fractured shaft of the tibia or femur. Many surgeons have exaggerated ideas of the tendency of muscles to produce displacement. They have some tendency to contract spasmodically immediately after an accident; but this soon passes off, particularly when they are firmly and equally compressed.

The apparatus for the treatment of fractured clavicle are too numerous to mention, and perhaps the simplest and best is Sayre's method with three strips of plaster. But I will venture to say that better results will be got by encasing the patient, with his ordinary jersey on, thoroughly in a plaster-of-Paris bandage, than by any other method. The clavicle being a short bone, it is of course necessary to fix the shoulder-joint by encasing the humerus and fixing it to the side; but it is quite unnecessary to fix the elbow-joint, which should be left exposed, the fore-arm being carried in a sling and used with moderation.

Fractures of the neck of the humerus may be similarly treated, if the axilla be thoroughly padded with cotton-wadding, and without a shoulder-cap, which latter is always cumbersome and very apt to gall the patient.

Fractures of the shaft of the humerus may be treated with plaster from the first, alone or combined with three splints; but fractures low down,

and separation of the lower epiphysis in young children, I find best treated by thoroughly flexing the forearm upon the chest and maintaining it there with ordinary bandaging.

Fractures of the fore-arm are the only ones which seem to me unsuited for treatment with plaster-of-Paris, and for the obvious reason that there would be great danger of drawing the two bones together. Two simple splints, not too wide, should be applied while the fore-arm is supinated, and then brought by the surgeon into the position between supination and pronation: these answer every purpose, while for Colles' fracture Carr's splint is the best. In fracture of the olecranon, I am heterodox enough to flex the arm to a right angle and let the patient wear it in a sling, and the result is as satisfactory as if a front straight splint were applied for a month. — *British Medical Journal*.

SURGICAL DISEASES OF THE KIDNEY.

At the Annual Meeting of the British Medical Association Mr. Clement Lucas opened a discussion on "The Surgical Diseases of the Kidney, and the operations for their relief," of which the following is an abstract. He commenced by stating that the greatest advances in the treatment which had taken place of late years were those made in the indefinite border-land which separates medicine from surgery. It was in this barren and desolate tract we must look for fresh discoveries. Ovariectomy and the various operations upon the intestines and stomach he put forward as instances of work recently advanced in this territory, but he claimed as the most remarkable incident of this decade, the sudden light which fell upon the profession in its relation to renal disease and the rapid growth and recognition of renal surgery. The credit of having awakened a new interest in renal diseases, and of having, by experiment on the lower animals, made sure of his ground, was due to the late Professor Simon, of Heidelberg, who in 1869 successfully performed nephrectomy for the cure of a fistula of the ureter following ovariectomy. Since then, extirpation of the kidney has been performed upwards of a hundred times. The operation of nephrotomy has been much more frequently undertaken, and the removal of a stone from the kidney which used only to be attempted when a sinus or tumour existed, has been several times successfully performed before the kidney had suffered any severe damage.

In casting a glance over diseases of the kidney to determine which might admit of surgical treatment, it was necessary to exclude at once all such diseases as attack equally the two organs; hence, the various degenerations, included under the name of Bright's disease and lardaceous disease

must ever remain outside the province of renal surgery. On the other hand, conditions which disturb the functions of one organ only, for the most part admit of relief by operation.

Painful, moving or floating kidney being only a mechanical disturbance admits of relief only by mechanical means. Simple exploration and replacement through an incision in the loin would probably be found sufficient in the majority of cases for the cure of this condition. The adhesion resulting, serving to retain the organ in position. Stirring of the capsule to the parietes, or, as it is termed, Nephroraphy, is a somewhat serious, but still simple, undertaking. In eight cases in which it has been performed the patients all recovered and were relieved. There might still be cases where intense suffering was experienced and where the other means had failed, which would suggest Nephrectomy. Martin of Berlin had in six cases removed floating kidneys through the peritoneum and four of these recovered.

Hydronephrosis, a dilatation of the pelvis and calices of the kidney with watery fluid as a result of obstruction below, admitted of surgical treatment when one-sided. After detailing the various conditions of the ureter, congenital and acquired, which might give rise to this condition, the author suggested these cases should be first aspirated, then cut down upon and drained through the loin; the cyst-wall being stitched to the parietes. Finally, should the fistula fail to close, the remains of the kidney might be returned through the loin.

In women these tumours had been often mistaken for ovarian tumours and had been operated upon as such. Being movable and not forming adhesions till late, some might advocate ventral nephrectomy for these cases before drainage, but such treatment would entail more risk than the method advocated. Abdominal nephrectomy for hydronephrosis will, however, show better results than nephrectomy generally.

Large isolated cysts of the kidney having no communication with the pelvis were rare. They should be aspirated and afterwards drained through the loin.

Hydatids of the kidney, also rare, had a tendency to discharge themselves through the pelvis. When forming tumours, they could generally be cured by aspiration or syphon-tapping.

Pyonephrosis, which resembles hydronephrosis anatomically, but contains pus instead of urine or watery fluid, when unilateral falls under renal surgery. The double pyelitis, with suppuration and distension, which commonly resulted from stricture and enlarged prostate, the author said was inappropriately named "surgical kidney." He suggested the term *Reflux Pyelitis* as better expressing this condition. Reflux pyelitis when one-sided was due to some obstruction in the ureter and then often gave rise to a large pyonephrosis.

Other causes of unilateral pyonephrosis were calculus and strumous pyelitis. After speaking of the diagnosis and stating that these tumours were more adherent, and gave rise to more pain and constitutional disturbance than hydronephrosis, he said that nephrectomy for pyonephrosis had been performed twenty-eight times and of these seventeen recovered and eleven died, but it was most worthy of notice that among these twenty-eight cases six had previously discharged their contents through a fistula in the loin and all these recovered. Hence, he argued, it was better to drain a pyonephrosis before performing nephrectomy.

Neoplasms of the kidney could only be treated by nephrectomy, and if this were performed early, there might be a good chance of permanent benefit. Generally they were too large to be removed except through the peritoneum, but of 5 cases removed through the loin, 4 recovered. Out of 16 removed by ventral incision, 10 died and 6 recovered.

Calculus of the kidney offered an excellent field for surgical interference, but the difficulty was to make sure of the diagnosis. Many cases of supposed calculus would turn out to be strumous kidneys. Two cases were related in which the kidney was explored and even deeply punctured but no ill-result or rise of temperature followed, and the wounds healed primarily. Several cases of nephro-lithotomy were recorded in the Clinical Society's Transactions and two cases had been performed successfully at Guy's Hospital during the present year. When the kidney was much dilated and damaged it would be a question whether it might not be better to remove it.

After briefly alluding to *Injuries to the kidney*, which, though not included under the title of the paper, might suggest nephrectomy, the author proceeded to speak of some details in operating. He recommended for the lumbar operation a combination of two incisions which he had employed as giving the most room, viz.:—an oblique incision higher than the colotomy incision within about half-an-inch of the last rib and parallel with it, and a vertical incision on the outer margin of the quadratus lumborum extending from the upper edge of the last rib to the iliac crest. For the transperitoneal operation Langenbuch's incision external to the rectus muscle was to be preferred to the median incision, as it enables the operator better to reach the kidney through the outer layer of meso-colon.

In conclusion, he urged, that antiseptic exploration of the kidney through the loin is a simple and not at all a dangerous operation, which may be undertaken without anxiety in any case where calculus is suspected; that it is generally wiser to tap and drain fluid tumors of the kidney before proceeding to remove the diseased organ; that when nephrectomy is decided upon, the extraperitoneal operation through the loin should always be chosen

for any tumour it is possible to withdraw through the limited space at disposal ; finally, if this course be adopted the transperitoneal operation will be reserved for large solid tumours, and, perhaps, some floating kidneys.—*Brit. Med. Journal.*

NEW METHOD OF REDUCING DISLOCATIONS AT THE ELBOW-JOINT.

Dislocations at the elbow-joint are generally reduced without much difficulty, but the operator occasionally encounters an amount of resistance which demands pulleys or assistants. In other instances, in which a complicating fracture is suspected or recognized, considerable force may be essential to the diagnosis or the treatment, and it is expedient that, while perfectly under control, this power should be applied with great steadiness. Again, in long standing dislocations, accompanied by extreme rigidity and consequent loss of function, authority, with the object of permitting efficacious treatment by passive motion, sometimes sanctions the fracture of the olecranon process. In any of those contingencies the following procedure permits of the necessary treatment in the most satisfactory manner.

The operator sits on the corner of a table, at the end of which the patient is placed upon a chair (Fig.) The injured limb is drawn under the surgeon's proximal thigh, which rests, close to the joint, on the anterior surface of the humerus, while the olecranon is accurately placed on the anterior surface of the lower third of the distal femur, and the proximal foot is "hitched" behind the other leg, which is flexed firmly against the frame of the table. In order to obtain the most favourable fulcrum, the surgeon fixes his proximal elbow against the antero-internal aspect of his corresponding thigh (not correctly shown in Fig.) and, grasping the wrist of the patient with both his hands, reduction is effected by the simultaneous and co-operative action of the muscles of the arms, back and thighs. Fixation and counter-extension are supplied by the powerful thighs of the operator, and coaptation is effected, with great nicety, by the backward pressure of the proximal femur against the anterior surface of the humerus, while the distal femur forces the olecranon forwards. Owing to the accuracy with which it can be applied, this power which is incalculably greater than that afforded by the pressure of the fingers and thumbs (Boyer), is sufficient when the forearm is steadied, to reduce an ordinary dislocation without the aid of extension. Additional adjusting influence is exercised by the inner side of the proximal thigh, which by pressing against the anterior surface of the forearm, liberates the coronoid process from its position behind the lower extremity of the humerus, and allows the greater sigmoid cavity to

resume its normal relation to the trochlea. Extension is supplied by the muscles of the upper extremities acting round the fixed point provided by the elbow of the surgeon, and, when his body is thrown backwards, additional force is derived from the muscles of the back, the glutæi, and the other extensors of the thighs. This power may be applied at various angles in rapid and easy succession, an advantage which the surgeon experienced in the treatment of dislocations cannot fail to appreciate.

In the lateral modifications of the posterior luxations the reduction is generally effected by the same manœuvre which is employed for the simple form of dislocation, but should special coaptation be necessary, it is at the disposal of the operator, as, when aided by the powerful constraining pressure of the thighs, the proximal hand can supply



sufficient traction and stability, while the other is unoccupied and in the most advantageous position to apply any additional manipulation which may, if desirable, be afforded by an assistant. If the condition be such that the full extending force of both arms be required, the isolated rural surgeon can, with a little ingenuity, render himself independent of professional aid by fixing the bone of the arm or forearm, which is displaced inwards, by a bandage passing round his own loins, and by making lateral traction on the bone or bones displaced outwards, by another bandage attached to his foot, and passing over his knee as over a pulley. By this simple apparatus the distinctive motions, which are essential to the reduction of the simpler luxations are utilised for the treatment of the more complicated forms.

For the anterior dislocation, of which the writer has had no personal experience, the following modification of the foregoing method is proposed, as being rational and obviously advantageous. The operator and patient being placed in the same

relative positions, the arm of the latter is passed over the proximal thigh of the surgeon, while his distal thigh is placed in the antecubital fossa; the distal foot is "hitched" behind the other leg, and the proximal elbow placed upon the shoulder of patient. The arm being fixed, and the forearm pressed against by the distal thigh, the operator grasping the wrist as in the former manœuvre, makes traction upon it in the most desirable direction, and, flexing the forearm over the thigh, he liberates the olecranon from the antecubital fossa, when the reduction is completed by the spasmodic action of the patient's triceps, aided, if necessary, by the operator, who forces the forearm backwards.

In addition to the desire to place at the disposal of the surgeon another method of dispensing with pulleys, assistants, and anæsthesia, the purpose of this paper is to direct attention to the undeveloped mechanical resources of the human body. The utility of the powerful muscles of the lower extremities in supplementing the strength of the upper, is a topic worthy of consideration, and experience has enabled the writer to commend it most warmly to the attention of his professional brethren—*Dub. Four. Med. Sci.*, July.

THE MANAGEMENT OF PARTURITION.

Dr. R. Tauszky read a paper before a recent meeting of the New York Academy of Medicine (*American Journal of Obstetrics*) opening with the question, Why is it that almost every woman, as soon as she becomes a mother begins to suffer from some form of pelvic disease? He believed much of this suffering to be due to meddling (unscientific) midwifery. Intelligent and anti-septic midwifery, even though having the appearance of "meddlesomeness," should however, he believes, be applied at every labor in order to the best possible physical condition of the woman. The first step towards this end are clean hands on the part of the accoucheur. His nails should be scrupulously clean, and the hands, after having been thoroughly cleaned with soap and water, should be washed with a three-per-cent solution of carbolic acid. All instruments and articles used about the woman should be similarly cleansed and disinfected. Just prior to confinement, or in the first stage of labor, the bowels should be emptied by an enema, repeated if necessary. The bladder, too should be emptied by the catheter, if necessary, and the vulva bathed with a weak solution of carbolic acid or thymol.

During labor dilatation of the cervix should be carefully assisted by the fingers, and much advantage may accrue from gently pushing the anterior lip above the symphysis. Tough membranes should be ruptured. Chloroform should be used in primiparæ, but not to the extent of complete uncon-

sciousness. The head and shoulders should not be allowed to press unduly for any considerable length of time on the perineum. To relieve such pressure apply the forceps.

The cord should not be tied until the umbilical vessels have stopped bleeding. This is a very important practical point. Crede's method of removing the placenta should be employed. The genitals should be carefully inspected after removal of the placenta, and any abrasion or laceration dressed with iodoform. The abdominal binder should be used and the child should be applied to the breast at the earliest possible moment. The early application of the child is in the interests of both child and mother, exciting necessary uterine contractions in the latter. In multipara a drachm of ergot should be given after the delivery of the after-birth. In normal labor ergot should never be given before expulsion of the child. [This statement we regard as both correct and incorrect. It is correct if it is intended to imply that the action of the ergot should not be secured on the undelivered child in normal labor; incorrect if the statement is intended to cover the mere act of giving the drug. It takes from ten to fifteen minutes for the ergot to act, and the experienced obstetrician can so time the exhibition of it as to secure its action after the delivery of the child, and at a time when its action on the uterus may be all-important in preventing hemorrhage following the removal of the placenta.—*Ed. Medical Age.*]

The thermometer should be placed twice a day in the axilla, that any ominous rise in the temperature may be promptly met. As an application to excoriated nipples the following:

R	Balsam Peru.....	3 j.
	Olei amygdal.....	3 jss.
	Aquæ rosæ.....	3 j.
	Mucil. acaciæ.....	3 jss.

M. Sig. Apply after last nursing, the nipples having been carefully cleansed.

Dr. Tauszky lays special stress on the necessity of preventing unnecessary hæmorrhage after parturition, and would hold the accoucheur responsible for the oozing of blood from the genitals for days after delivery. He maintains that not a drop of blood should be lost after the third stage of labor, and that the napkins should be perfectly free from color. Should even slight discoloration occur, the source should be looked for with a view to checking it.

The bowels need not be moved until the third day after labor. Intra-uterine carbolic injections should be used only when the lochia are offensive and when there is febrile movement. Even in such cases he thinks vaginal disinfecting injections are alone sufficient, except in cases in which the uterus has been injured. As such injections he prefers thymol to carbolic acid, and the parts should be thoroughly cleansed by inject-

ions of simple water, either through a soft catheter or by means of the Chamberlain syringe.

Dr. Tauszky protests very strongly and very properly, in our opinion, against Dr. Goodell's plan of allowing the woman to resume the upright position within three days after labor. His frontier experience with the army convinced him of the fallacy of the belief that squaws are free from uterine trouble. Uterine affections are not uncommon among them, and they are due, in his opinion to early rising after parturition.

Should pelvic peritonitis develop, he regards cold applications as the best, especially in the early inflammatory stages. At first the applications must be made very frequently. He exhibited Leiter's (of Vienna) device for reducing intra-pelvic temperature. It consists of metallic cylinders three-quarters of an inch to an inch and a quarter in diameter and two inches in length, within which were coils which terminated in two extremities, which projected from the extremity of the metallic bulb, and to which India rubber tubes could be attached to conduct water from a fountain above through the bulb into a basin below. He regards warm injections for peritonitis as dangerous.

In the discussion which followed Dr. Tauszky's paper, the views contained therein were generally endorsed, but the position in which he insisted on the necessity of absolute cessation of hæmorrhage after the termination of the third stage, was freely criticised. The value of cleanliness was emphasized, as was also the necessity of securing a condition of good health in the woman prior to parturition. Dr. Tauszky, in reply to his critics, again insisted on the possibility of absence of blood after expulsion of the placenta. To this end the firm, hard feel of the uterus must be secured before the accoucheur leaves the woman.

PRACTICAL POINTS FROM PHILADELPHIA CLINICS.

The *Medical Herald* gives the following practical points from Philadelphia clinics:—

Dr. Carl Seiler removes polypi from the nasal cavities with the snare, as this causes less bleeding than the polypus forceps, and touches them with the galvano-cautery. This prevents the return of the growth, which nothing else will, the doctor having tried iodine, chromic acid, etc. This procedure certainly merits further trial.

Dr. Wharton recommends that superficially situated nævi be cauterized with strong nitric acid, applied with a glass rod. The resulting slough is followed by a white cicatrix. More extensive nævi call for other treatment.

For catarrhal, or herpetic, or diphtheritic tonsillitis Prof. Pepper recommends constitutionally absolute rest, large doses of quinine, drop doses of tincture of aconite, and liquid diet, and locally the application of the muriated tincture of iron.

Prof. Tyson often prescribes a mustard plaster prepared with molasses instead of water. For prolonged and mild counter-irritation this acts excellently, as patients often have the plaster on their backs for hours while fulfilling their daily duties. Dr. Tyson also has great faith in jaborandi and its active principle, pilocarpin, in the treatment of uræmia. He considers it *the* remedy for such cases. In Bright's disease and in diabetes the doctor prescribes an exclusive milk diet. He gives only skimmed milk.

Dr. Strawbridge poultices the external ear in the following ingenious manner: He lays the patient's head on the table and fills the external ear with as hot water as can be borne. Over the ear are applied towels soaked in very hot water, the surplus water being drained off by squeezing the soaked towels between dry ones.

Dr. Louis A. Duhring recommends for acne, sulphur in some form; preferably the sulphate of calcium internally, and locally the following prescription at bedtime: *R.* Sulphuret. potash, ʒ ss; sulphate zinc, ʒ ss; glycerine, ʒ j; alcohol, fl ʒ j; water, fl ʒ j. *M.*

For eczematous sores in children and old people recommends an ointment of five grains of iodide of lead to the drachm of vaseline.

Dr. Ellerslie Wallace describes nux vomica as the great invigorator of the sexual organs. He gives from one-half to one grain dose of the extract of nux vomica three times a day after meals.

Dr. John Ashhurst, Jr., says it is the surgeon's rule for ligation of an artery to cut down over the pulsation of the artery where he feels it. Of course the surgeon should know the anatomy of the parts, as well as the lines for cutting as laid down in the books.

Prof. Da Costa says do not aspirate pleuritic effusions as long as no urgent symptoms, such as failure of the heart and symptoms of blood-poisoning, demand it, for the liquid will generally re-accumulate, and the second time it will be purulent. Give iodide of potassium and other remedies to promote absorption and to make the kidneys act. For the latter the infusion of juniper and jaborandi internally, and dry cupping over the region of the kidney will be often of benefit.

Prof. Tyson divides the treatment of acute rheumatism into three kinds to suit different types of cases. Rheumatism occurring in persons of nervous rheumatic temperament who lead a sedentary life, but are otherwise well fed and clothed, should be treated by salicylic acid or the salicylate of sodium; twenty grains of the latter every four hours for the first twenty-four or forty-eight hours. Continue the medicine after convalescence is established for some time.—about as many days as the disease itself lasted. Rheumatism occurring in obese persons who are free livers and who use malt liquors will be best treated by the alkaline treatment. One

and a half drachms of bicarbonate of soda in lemon juice every four hours for four days, afterward twenty grains three times a day combined with iron and quinine. Rheumatism occurring in anæmic persons who have been underfed and overworked should be treated with the tincture of iron. When the types shade into each other give the salicylic acid with the other treatment. The diet should consist of skimmed milk, chicken or mutton soup, beef broth or other liquid diet. Anodynes and the old "six-weeks-abad" have gone out of date.

Dr. Wm. Goodell, the world-famed gynecologist of the University recommends for pruritus vulvæ : R. Carbolic acid, ʒ j ; morphine sulphate, gr. x ; boracic acid, ʒ ij ; vaseline, ʒ ij. M. And also the patting of the parts with a sponge soaked in boiling-hot water. This is also a most excellent application for that rawness so often found between the thighs of the newly born.

THE THERAPEUTICS OF BLUFF.

The *New York Medical Record* gives the following sketch :—He stood by the bedside counting the pulse, counting the respirations. The patient was in advanced life, and was suffering from broncho-pneumonia. "One hundred and six!" was the exclamation ; "respirations thirty-six, an increase over last evening of ten pulsations and six respirations. Some slight lividity of the extremities of the fingers. Heart's action a little irregular." Dr. Blank shook his head dubiously. "Mrs. Brown is not so well to-day." A cloud passed over his countenance as he spoke the words ; it was noticed by Jane, Thomas, and Susan. A gloomy silence followed. The Cammann binaural tube was applied to different parts of the thorax. Subcrepitant ronchi everywhere ; small bubbling at the bases. "There is extensive consolidation," he said ; this dull region is stuffed with the products of inflammation. It is a hard tug for breath with the old lady."

The supreme cortical cells of Dr. Blank's cerebrum were involving this thought : "This patient will die ; I shall lose prestige in consequence ; I shall lose the patronage of this family." What shall he do about treatment ? The digitalis does not seem to be working well ; there is nausea. The squills, senega, and ipecac do not promote expectoration. There is pain in the head, and he fears that it is caused by the quinine and whiskey. In doubt and uncertainty he tells them to put these medicines on one side, and writes a prescription for some carbonate of ammonia. He directs full doses of this medicament, and then, after starting for home, in his hesitation comes back and advises the family to give only half the dose prescribed. With a heavy heart, which his countenance too plainly shows, he bids the Browns good-morning.

What are Thomas and the Brown girls thinking about at this time ? "This man is fairly discouraged. He has done all he can. He has no confidence in his medicines. He has made a complete change, and now is doubtful about the result of the change. He evidently thinks mother is going to die. Mother, too, is discouraged. It is time to try somebody else." Dr. Blank had hardly arrived home that morning when a messenger brought a note from the Browns stating that they had made a change ; that Dr. Blank might consider this note a note of dismissal ; that Dr. Bluff would now take charge of the case.

Dr. Bluff was not in any sense a scientific man, nor had he any skill in the selection of his remedies. He stole a good many useful hints from members of the faculty and young graduates, with whom he now and then held consultations (and with whom he always agreed), but his diagnosis was hap-hazard and his treatment was hap-hazard. He drove fast horses, and would bluster like an English country squire. All this gave him great popularity. Individuals had been heard to say that they would rather have Bluff's presence in a sick-room, if he did nothing more than talk slang, and tell them that they would be able to dance a polka in a few days, than have the most scientific college professor who would give them nauseous medicines, and tell them that their sickness was of a very grave nature.

Dr. Bluff was ushered into the room of the sick Mrs. Brown. The diagnosis and the fearful prognostications of poor Dr. Blank were turned to ridicule. There was nothing the matter with Mrs. B., only "a little stuffing" in the chest. He "would clear out those pipes in less than no time." Whiskey and milk and his white emulsion of ammoniacum was all that was necessary. In less than half an hour the vocabulary of banter and current slang was exhausted. The sick woman was a "daisy," a "blooming rose of Sharon," and a "gay old gal." She had not "got through her *sparkling*" yet, and "if the present Mrs. Bluff should ever be taken off he would improve his opportunity," etc. As for dying,—"*Fiddlesticks!* she cannot die with *that* pulse." He would "have her out of that bed scrubbing the kitchen floor before a week."

It is needless to say that the Browns were all delighted with the assurance and the jocoseness of their new family physician, whose encouraging words rallied them to renewed efforts to prolong their parent's existence by often-repeated potions of whiskey and milk. It is worthy of note, too, that the patient herself for a while felt the invigorating stimulus of a new hope. Although the final result was as Blank predicted, yet there always was a feeling on the part of the Browns that if Bluff had been called a little earlier the result would have been different.

The above is no imaginary picture. Dr. Blank

and Dr. Bluff are the prototypes of many men who honor or dishonor our noble profession. The latter will generally be the most popular, if not the most successful. We do not believe in *bluff*, but encouraging words and smiles are often of real therapeutic value.

WHAT IS A CONSULTATION?

Dr. H. R. Hopkins, in the *New York Medical Journal*, says that although he is a new code man he accepts Dr. Squibb's statement of what constitutes a consultation under the meaning of the old code. Farther, he says that if this be the general accepted view of the code then the parties to the present controversy have been looking at opposite sides of the same shield.

But we give Dr. Squibb's illustrations which contain the matter in a shape more readily grasped: "If a surgeon or other specialist be sent for by a patient or by an irregular physician and treats any special case by his own skill and principles of judgment—no matter whether the irregular continues to see the patient or not—is that a consultation? Certainly not, for there is no council held, and no violation of principle, but on the other hand, there is a triumph of principle against which want of principle cannot long stand, for honesty and truth and justice and humanity all underlie and support such action, and therefore the old code supports it. Is a practitioner when summoned, whether in emergency or not, to stop to inquire who he is to meet at the bedside in order to avoid heterogeneous consultations, as if he were mortally afraid of them? Certainly not, since even the meeting with irregulars does not constitute a consultation with them; and if he meets them and does his best for his patient, without admitting professional fellowship, and without holding council, or permitting the appearance of holding council, and holding out to the patient a free choice as to whom he will choose to conduct his case, and stating the plain reason why he cannot have both, there is no consultation and no conflict with the old codes of ethics. If a physician be sent for to meet one or more irregular practitioners in consultation upon a difficult or critical case must he decline the meeting? Certainly not. He may go. And perhaps if his sense of moral rectitude and justice be very high, he may decide that he must go. But he will most certainly decline consultation when he gets to the meeting. He will make clear his readiness to see the patient if that be desired, and to do the very best he can for him; but he will distinctly decline to do it jointly with those whose avowed or tacit principles of action are so antagonistic to his that only one side can be right. If the patient or his friends insist in the name of humanity, and for the sake of a beloved child or relative that he should remain

in joint management and assist by his counsel and experience, is he then justified in such consultation? No; for if he cannot make the patient and friends understand that the presence of either the regular or the irregular practitioner must in the nature of cause and effect be detrimental to the interests of the patient, then he must withdraw by force of his own principles of probity and honor, and submit to popular adverse criticisms, and even newspaper misconstruction and abuse if need be. But first he will earnestly strive to convince the patient that either course of treatment is surely better for him than any admixture of incompatibles. If at the request of a patient or his friends a regular practitioner takes charge of a case, and an irregular practitioner is by the family retained in attendance, even if visiting the patient at the same hours, or present at the treatment, is this a consultation? Not if there be no holding of council to deliberate upon the case, no acknowledgement of a joint responsibility, no admission to professional fellowship and equality, nor any admixture of treatment. The irregular is not then a consultant but a spectator, or may be even a nurse.

"The line is not difficult to draw in any of these cases, and although it will not be exactly the same line as drawn by different individuals under different circumstances, yet it will always be coincident in effect if drawn in obedience to the plain rules of honor and honesty and the plain meaning of words. And if it be carefully drawn with that unselfishness which first thinks of the feelings of others, it will always be done with politeness and courtesy."

The writer of these positions states that such is his own personal view of the matter. It strikes us that his view will be that of the mass of those who support the old code. Liberality, humanity and honesty are its simple planks. Those who desire to abide by these will find them quite fully and plainly delineated in the old code, if only they look for the truth.—*Detroit Lancet*.

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GONORRHOEA EASILY CURED.—Dr. Z. T. Dellenbaugh (*Coll. and Clin. Record*), says I have for eight or ten years, used carbonate of lithia to alkalize the urine; and find the five-grain compressed tablets, one taken three times daily, very convenient, fulfilling every indication better than any other salt. I now rarely find it necessary to give any other remedy internally.

Should the case fail to respond to the following injection, and not show marked improvement in two or three days, two sandal-wood oil capsules may be given, three times daily, for three or four days. The injection I have used in cases of acute and sub-acute gonorrhœa for more than a year, with the most gratifying results, especially to the patients, who have recovered in from two to seven days,

and paid me from one to three visits, is the following: *R.* Resorcin, 3 j; acid. boracic, gr. xx; zinci acetatis, gr. $\frac{1}{4}$ — $\frac{1}{2}$; aquæ destillat., f. 3 iv. *M.* Of this solution, two teaspoonfuls are injected three times daily. The germicides, resorcin and boracic acid, are so slightly astringent, that it requires the additional zinc salt to restore capillary tonicity. This injection is quite or nearly painless.

In the treatment of the latter stage of sub-acute and chronic gonorrhœa, without stricture or granuloma as a complicating factor, I have had the happiest results follow the use of the following injection: *R.*—Hydrargyri chloride corrosive, gr. $\frac{1}{4}$ —ss; zinci chloridi, gr. ss—j; aquæ destillat., f. 3 viij. *M.* Sig.—A tablespoonful to be injected well down into the urethra, three times daily. Corrosive sublimate injections are by no means a recent addition to the list. The rationale of their use, however, is recent. As in the injection for acute cases, the germicidal constituent must be so sparingly used (otherwise it produces great pain and reactive inflammation), that I find it very advisable to combine a more astringent salt; and the chloride of zinc is the one I have selected, for obvious reasons. Without doubt, a mild injection of corrosive sublimate and chloride of zinc is destined to be the injection for sub-acute and chronic gonorrhœa.

SCRAPING VS. SCARIFICATION IN LUPUS.—In a paper read in the Section of Surgery at the annual meeting of the British Medical Association in Liverpool, August, 1883, Mr. Morris speaks highly in favor of free erosion by means of a blunt spoon. He remarks, "The plan I adopted was, with a few minor modifications, identical with that originated by Volkmann in 1870. With a large spoon all scabs are thoroughly removed, and with them the great bulk of the superficial desposit, and after drying the surface the minute nodules, which are deeply lodged in pockets of the corium, are dug out with smaller and pointed scoops. The margins are also vigorously scraped. The spoon should be applied till the whole of the soft friable lupus-tissue has been removed and only the firm resistance of the sound part is met with. Though the greater portion of the disease may be removed at one operation, some of the smaller deep-seated nodules which have escaped will reappear in the scar, and require subsequent treatment. After the healing of the wound produced by the operation a scar with more or less loss of substance is left."

In comparing scraping and scarification, he observed that though the former has the advantage of rapidity, in the character of its scar it is much inferior to the latter. Scraping is, after all, a destructive method, similar to, though milder than, the older forms of treatment, as it mechanically removes the diseased material, whereas scarification is essentially conservative in its action. The

incisions, by cutting off the blood-supply, modify the nutrition of the growth, and lead to its atrophy with a minimum loss of substance. In addition, in the severe forms of lupus exedens, in which scraping fails, or even aggravates, scarification acts most rapidly and completely. A further though minor advantage is that scraping, on account of the pain, requires an anæsthetic, which can be dispensed with in scarification.—*British Medical Journal*.

IPECAC. IN INDIGESTION.—"A century of experience tells of the utility of ipecacuanha in indigestion. It was a constituent of the dinner pill of the last century. Not only does it stimulate the liver, and so be useful in cases of indigestion where there is either bile acids formed in excess or lithates present (that is, the peptones which find their way into the portal vein from the intestinal canal, and which, converted into proteids, and elaborated into the albumen of the liquor sanguinis by the liver normally, are transformed instead into the bile acids or urates: the patient loses flesh, and on a flesh dietary only makes more bile or more lithates without gaining weight), but ipecacuanha is a 'pepsin persuader' from its action on the gastric lining membrane with its multitudinous glands and follicles. Ipecacuanha combines properties, indeed, as does no other agent, in my opinion. Then there is often atony, either general or in the bowel, and for this strychnia is an admirable remedy. Perhaps, too, flatulence, for which a carminative is indicated. Then there is the vehicle, which may or may not be a laxative, according to the case. The pill would stand then somewhat as follows: *R.* strychniæ, gr. 1-20; pulv. ipecacuanha, gr. 2-2; pulv. piper. nig. gr. iss; ext. gentian, gr. i."—*Fothergill*.

SUCCESSFUL MEDICAL JOURNALISM. — Dr. H. V. Sweringen, in the *Indiana Medical Journal* says: "The journal which exercises the greatest acumen in the selection for publication of the more everyday practical points interspersed with occasional recreative collaterals, has caught the spirit and genius of successful medical journalism." "The reader is much more interested in the treatment of the disease than he is in its history, etiology and pathology, notwithstanding the fact that the success of the former is more or less dependent upon some knowledge of the latter." "I doubt whether three-fourths of the long drawn out papers which are published in our various medical periodicals receive more than a mere passing glance, no matter what may be their merit."

HÆMOPTYSIS. — Dr. Brown (*Med. Brief*), says: Of drugs, ergot seems to be the most powerful in checking hæmoptysis. Thus the extractum ergotæ fluidum may be given in doses of a teaspoonful every

fifteen minutes, until the hemorrhage is stopped, and then continued in smaller doses, or it may be given by hypodermic injection, in doses of fifteen drops, or ergotine may be used. If the stomach is irritable, ergotine may be given per rectum. Sometimes ergot will have no appreciable effect. Under such circumstances I think that gallic acid is the next best remedy. I frequently combine it with sulphuric acid, which makes a more efficient and pleasant mixture: R. Acidi gallici, 3 ij; acidi sulphurici aromat., 3 j; glycerinæ, 3 j; aquæ, q. s. ut. ft., 3 vj. M. Sig.—A tablespoonful, as required. This is to be given every half hour or at shorter intervals, until the hemorrhage is brought under control. This, I think, ranks next to ergot, and where the stomach refuses ergot, or where ergot produces no effect, I usually resort to this combination.

WHEN NOT TO GIVE CHLOROFORM IN PARTURITION.—In a paper read by Dr. Savill before the East Surrey District of the Southeastern Branch of the Medical Association, he lays down the following rules to be observed in not giving chloroform during labor:

1. Never give it to a woman who has a tendency to flood during every confinement, or to those who have great relaxation of fibre—or weak, anæmic women in their eighth or tenth confinement, except for necessity.

2. Do not give it where labor is complicated with severe vomiting, or with acute heart or lung trouble, unless there be an imperative demand for it.

3. It should not be given to complete anæsthesia, except for operations, convulsions, or spasms of the cervix, and then one person should devote his entire attention to it.

4. The inhalation should be stopped directly the pulse becomes weak or the respiration irregular.

5. Do not give it if there be grounds to fear a fatty or enfeebled cardiac wall.

6. In all cases where it has been given, there should be extra care to prevent post-partum hemorrhage.—*The Obstetric Gazette*.

SALICYLIC OINTMENT FOR ECZEMA. — In eczema of the scalp in children, Dr. Lassar *Monatshfte für praktische Dermatologie*, 1883, No. 4) recommends, after cleaning the surface,—

R. Acid. salicylic., 1 g.;
Tinct. benzoini, 2 g.;
Ung. petrolei, 50 g. M.;

to be employed two or three times a day.

In eczema of the non-hairy portions he employs,—

R. Acid. salicylic., 2 g.;
Ung. petrolei, 50 g.;
Zinci oxidi,
Amyli, aa 25 g. M.

This paste is absolutely unirritating, and besides, has the advantage that it does not retain the exudation upon the skin, but allows it to escape through it.—*Centralblatt für Chirurgie, Med. Times*.

DR. BARKER, of New York, believes, (*American Journal of Obstetrics*, October, '83,) that mechanical obstruction as a cause of dysmenorrhœa exists in only a small percentage of cases; that there are two forms of the disease, one uterine and the other ovarian. In the uterine variety there are cases which do not depend at all upon obstruction, the pain is due to the effort of the uterus to relieve the plethora by the rupture of capillaries and exfoliations of mucous membrane. He uses the lactate of iron in doses of from three to five grains three times a day, associated with chlorate of potash; as soon as the symptoms of menstruation begin he gives apiol, which he looks upon almost in the light of a specific. In ovarian dysmenorrhœa there is no pain until the flow has continued for two or three days; when the cause was ovarian, the bromide of sodium in ten to fifteen grain doses in the middle of the forenoon, in the middle of the afternoon and at bed time, was the proper treatment.—*Weekly Medical Review*.

IN reference to menstruation after extirpation of the ovaries, the following professional opinions have been lately given (*American Journal of Obstetrics*, October, 1883): Dr. Campbell, of Georgia, does not deny the influence of habit, periodical plethora, the ovaries and the Fallopian tubes, but he thinks there is a certain endowment of the nervous system. Dr. Goodell puts it that there is an irritation of the nervous bulb. Dr. Emmet had a case in which both ovaries were removed together with the Fallopian tubes, and yet there had been a regular menstruation thirteen times. Dr. Thomas said, as a rule, if the ovaries are removed, menstruation is the exception. If it occurred, it was due to a metrostaxis. The only benefit of Tait's operation, over Battey's, was that all the ovarian tissue was more likely to be removed. Dr. Byford believes that in many cases some of the ovarian tissue was apt to be left, that it is difficult to remove all of said tissue.—*Weekly Medical Review*.

DR. J. M. DA COSTA has been testing the therapeutic value of the salts of nickel. The sulphate proved of some value in obstinate diarrhœa. The bromide, however, is the most valuable of all, and will probably take a permanent place in the materia medica. Its action is similar to the other bromides, but a much smaller dose suffices. Five to seven and a half grains is an average dose, and ten grains is a decided one. It relieves congestive forms of headache and quiets the system generally. In epilepsy it does quite as well as other bromides,

but, as above mentioned, a much smaller dose suffices.—*Med. World.*

IODIDE OF POTASSIUM IN FRONTAL HEADACHE.—Dr. Haley, in *Australian Medical Journal*, claims that minimum doses of iodide of potassium is of great service in frontal headache. A two-grain dose dissolved in half a wineglass of water will often cure a dull headache which is situated over the eyebrow. The action of the drug is quite rapid.—*Medical Summary.*

THE ETHER SPRAY AS AN IMMEDIATE CURE FOR NEURALGIA.—In the *Philadelphia Medical Times*, February 10, 1883, Dr. McCollgann highly endorses the ether or rhigolene spray for the immediate relief of neuralgia, especially of the portio dura of the 7th. He first tested its efficacy upon himself, with excellent results, and subsequently used the application in a series of twenty cases, with remarkable success. In many cases a permanent cure resulted. He explains its action by supposing that a complete alteration in the nutrition of the affected nerve occurs, in consequence of the intense cold acting as a revulsive."

TREATMENT OF EMPYEMA OF THE PLEURA. By Courvoisier.—1. Every empyema, like an abscess, should be opened early.

2. For this, (a puncture with aspirator and washing out) only in very acute cases. In chronic cases, puncture is used only for diagnostic and palliative purposes

3. Intercostal incision is applicable only in acute and simple cases.

4. Resection of one or two ribs is indicated in all chronic and complicated cases, with a tendency to slow healing.

5. The multiple, non-subperiosteal resection of ribs is always used in chronic, hard-walled empyemas.—(*Correspond. Schweizer Aertze.—St. Louis Med. and Surg. Jour.*)

NEW DIAGNOSTIC SYMPTOM OF PREGNANCY.—Prof. Osterich, in a lecture before the Society für Natur- und Heilkunde in Dresden, stated that the earliest, never-failing symptom of pregnancy is the *vaginal pulse*. It is found to the right, left and in the middle of the cervix. In healthy, non-pregnant women, it can only be felt when in a state of orgasm, but then all other symptoms of pregnancy are wanting. The lecturer never found the vaginal pulse wanting in pregnancy. Dr. Grouser confirmed the statement, as being the result of his own experience.

LOCOMOTOR ATAXIA AND SYPHILIS. So much has been said from time to time as to the causative relation between syphilis and locomotor ataxia, that it is well to look at the views on the subject.

(*Med. and Surg. Rep.*) There are many who hold that syphilis is a very common cause of locomotor ataxia. We now learn that French opinion is divided on the subject; in Germany the weight of opinion is in favor of a relationship, and in England the same view is gaining ground.—*Lou. Med. News.*

IRREGULAR HEART ACTION.—Dr. Bowditch (*Boston Med. and Surg. Journal*) highly praises the following:

R Pulv. digitalis, gr. x;
Pulv. colchici sem., gr. xx;
Sodii bicarbonatis, gr. xxx.

M. et div. in pil. No. 20.

One to be taken three or four times daily at first; subsequently to be reduced until only one is taken at bedtime; the treatment to be continued for from three to nine months. He has used it for twenty-five years, and has found it to relieve even the most serious cardiac affections.

FLATULENCE.—In flatulence, Dr. Bruen (Phila. Hosp.) prescribes a pill containing five grains of bicarbonate of soda and five drops of oil of eucalyptus two hours after meals. Pepsin or pancreatin with milk food and the mineral acids with meats should be directed to be taken immediately after meals.—*Exchange.*

A LINIMENT FOR RHEUMATISM.—The *Quarterly Therapeutic Review* says methyl salicylate (oil of wintergreen) mixed with an equal quantity of olive oil or linimentum saponis, applied externally to inflamed joints affected by acute rheumatism, affords instant relief, and, having a pleasant odor, its use is very agreeable.

IN FRANCE, children are kept from school forty days after having had small pox, measles, or scarlatina. For mumps and varicella the duration is 25 days. For diphtheria, 40 days, whether the attack is light or severe. Finally, before they can join their companions, their clothing must be disinfected, and they must take one or two baths with soap.

"WELL," remarked a young M. D., "I suppose the next thing will be to hunt out a good situation, and then wait for something to do, like Patience on a monument." "Yes," said a bystander, "and it won't be long after you do begin before the monument will be on patients."—*Phil. Med. and Surg. Reporter.*

Dr. Flint has recently tried oil of wintergreen in rheumatism in Bellevue Hospital. He gives ten drops several times a day in flax-seed tea or milk. The results have been better than with salicylic acid.—*Exchange.*

THE CANADA LANCET.

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THE PAST YEAR.

We are again upon the threshold of another new year, and as has always been our custom at this season we propose to take a retrospective glance at the work done during the year that has now come to a close. The labor of even a partial and incomplete review, as ours must necessarily be, of the events which have transpired in the medical world in this short space of time, is of no ordinary character, and we would gladly forego the task were it not that such a resumé, however imperfect and incomplete it may be, cannot fail to be of interest to most, if not all, of our readers, provided the references partake of a practical character. The progress of medicine is necessarily slow and sometimes even discouraging, yet the watchword is ever onward and upward. Many problems in the etiology, pathology and therapeutics of disease remain unsolved, and will no doubt require for their elucidation the combined labors of scientific observers the world over for many years to come. The investigations of scientists demand much sacrifice of time, and great patience and perseverance under difficulties, but the elucidation of truth brings its own reward—the highest of all distinctions, and the consciousness of a life not spent in vain. With the aid of instruments of precision much has been accomplished in minute investigation, which, a few years ago, would have been considered almost, if not quite, impossible. We have therefore much to be hopeful for, and much that is encouraging.

The subject of state medicine has received increased attention by the profession and the public both at home and abroad, during the past year. The Federal Government of the Dominion has given its attention to the subject, at the instance of the Canada Medical Association, and a liberal grant has been voted to give the scheme adopted a fair start. The collection of statistics in the large cities is but the inauguration of a larger measure of sanitary reform, which will prove of inestimable value to the people of this country. If the probable success of an undertaking may be measured by the activity displayed by those who are concerned in its promotion, then we have reason to be hopeful as to the future of this great question of sanitary reform. The large and influential deputations to Ottawa, and the meetings of sanitary organizations and the work accomplished, tend to show the interest that has been awakened on this subject and its probable result in the near future.

In medicine and therapeutics much valuable work has been accomplished, new ideas have taken the place of old and crude notions, and the curative action of remedies has been more accurately investigated and determined. The space at our disposal will not permit of a very extensive review of the many points of interest in this connection which might be alluded to, but we will notice a few that press themselves upon our attention. Dr. Sidney Ringer, (*Brit. Med. Journal*), referring to the dangers of bromide of potassium, chloral hydrate and opium in adynamic states, suggests the substitution of bromide of sodium in such cases as being less injurious, the sodium salts being only slightly inhibitory of the heart's action, whereas the potassium salts are ten times as active. This would seem to point clearly to the advantages of bromide of sodium as a hypnotic, and indeed as a substitute for bromide of potassium in very many cases. The bromide of sodium has also been highly extolled in the treatment of migraine, by Dr. Morton (*Med. Gazette*, July 21, '83). Drachm doses are to be given at the onset and repeated in an hour if the attack does not cease. Cod-liver oil and iron may be given in conjunction with the bromide. Nitrite of amyl and nitro-glycerine have also been used in the treatment of this and other allied affections. The latter is given in one to five drop doses of a one-per-cent. solution, three times a day. The etiology of erysipelas has received

considerable attention during the past year from Dr. Fehleisen, of Berlin, and his treatise on the subject may be regarded as another step in the perfection of our knowledge of the disease. Fehleisen succeeded in isolating the erysipelas micrococci and in propagating them by culture, and inoculating rabbits with these artificial cultured fluids, producing a disease absolutely identical with erysipelas. Hospital patients were also inoculated with like results. He then turned his attention to the therapeutics of the disease. The two agents tried were those used for the dressing of wounds in Bergmann's clinic, a one-per-cent. solution of corrosive sublimate and a three-per-cent. solution of carbolic acid. The former destroyed the disease germs after an exposure of ten to fifteen seconds, while the latter required about forty five seconds. In Bergmann's clinic where these antiseptics are used, only two cases of erysipelas occurred during a period of four and a half years. The collective investigation committee of the British Medical Association have presented a provisional report on the pathology of pneumonia, based on an analysis of 350 cases. The report is opposed to the doctrine that pneumonia is a specific fever, whose chief local manifestation is in the lung. It confers no protection upon the individual, but rather the reverse. It has no direct association with specific or conveyable disease, and its near alliance with tonsillitis is in striking contrast with its rarity in diphtheria. Its occurrence as an epidemic may be partly explained by atmospheric conditions, and partly by other agencies prejudicial to health. The report calls attention to the immunity from fatal pneumonia enjoyed by total abstainers, and the great fatality among the intemperate. It also emphasizes the dangers of high temperature in pneumonia, which suggests careful attention to the use of the thermometer, and the means of lowering the temperature in the treatment of this disease. It is now pretty well known that the tendency to death is by failure of the heart, and the effect of high temperature on its muscular wall cannot but be highly injurious. The committee hopes to obtain a *thousand* cases on which to base a complete report, and we trust the members of the Association and others will aid in the work, by filling up the cards sent them. Dr. Dinaud (*L'Union Medicale*, July 19, '83) has brought prominently under the notice of the pro-

fession the use of perchloride of iron, not only in diphtheria, but also in typhoid fever. In the former disease he regards it as almost a specific, and although he does not so regard it in typhoid, he believes it to be of great efficacy. The iron should be commenced at the beginning of the second week and continued until convalescence. In the *Brit. Med. Journal*, Dr. Hare makes a strong plea for the restoration of "good remedies out of fashion"—emetics and bleeding. He referred to the value of emetics in the early stage of croup, in the removal of false membranes in diphtheria, and in the relief of attacks of suffocative bronchitis, in all of which he had no doubt of their exceeding great value. With regard to blood-letting, he referred to its great advantage in engorgement of the right side of the heart, from whatever cause, and strengthened his position by referring to cases in illustration. In connection with the subject of bleeding, mention may be made of a novel method employed by Mr. Coppinger (*Brit. Med. Journal*, Sept. 15, '83) for abstracting blood. The needle of the aspirator was inserted into the jugular vein of a patient suffering from an overloaded vascular system, and four ounces of blood withdrawn. The operation being entirely satisfactory, the surgeon repeated it in the course of half an hour, removing six ounces more. The patient was greatly benefited and no bad results followed the procedure. Dr. Willcocks, of Charing Cross Hospital, London, Eng., contributes an interesting article on the pathology of anæmia and chlorosis and their treatment by iron and arsenic. The value of these remedies combined, in well selected cases, has been endorsed by many different observers. In the treatment of whooping-cough, Dr. Webb (*Am. Practitioner*) speaks very highly of croton-chloral. He gives it in grain doses to children one year old, and increases it to two grains for children ten years of age. The first few doses may cause irritation about the throat, but this soon passes away. The relief is so marked in some cases that patients fall asleep in their chairs. The therapeutic value of the salts of nickel have been investigated by Dr. DaCosta, of Philadelphia. The chloride, bromide, acetate, sulphate, and phosphate were the salts tested, and of these the sulphate and bromide proved the most useful. In obstinate diarrhoea excellent results were obtained from one to two-grain doses of the sulphate four times a day

In one such case, associated with valvular disease of the heart, it succeeded after other remedies failed. The tonic effect so much spoken of was not marked. It is slightly sedative and anodyne, and was found serviceable in chronic catarrh of the stomach. The bromide was found to allay headache, convulsive movements, and to act satisfactorily as a sedative to the nervous system. In epilepsy it acted quite as well as any of the bromides, and in one instance it succeeded after the others had failed to afford any relief. It lowers the temperature and reduces the pulse slightly. The dose is five to ten grains, a smaller one than that of the bromides generally being sufficient to produce the desired effect. The value of rhus toxicodendron as a remedy of the greatest certainty in rheumatism, has been brought to the notice of the profession by Dr. Gifford, of Indiana. He prefers the freshly prepared alcoholic extract, which he gives in small doses night and morning. Among the remedies for sea-sickness proposed from time to time, may be mentioned the hypodermic injection of from $\frac{1}{3}$ to $\frac{1}{2}$ a grain of acetate of morphine, which Mr. Vincent, of the Cunard Royal mail service, claims is by far the most useful of all remedial measures. The use of naphthol in the cure of scabies, has received special attention from Dr. Harlinger, of Philadelphia, (*Am. Jour. Méd. Sciences*) who speaks of it as the most efficient and agreeable remedy for scabies, yet brought forward. It was first introduced to the profession two years ago, by Prof. Kaposi, of Vienna. It is useful also in a certain number of skin affections, such as squamous eczema of the scalp, psoriasis, and seborrhœa. A substitute for morphine has been discovered in a leguminous plant called *piscidia erythrina*, which grows in the volcanic soil of Jamaica. It takes its name from its property of narcotizing fishes—a property taken advantage of by the natives. Its properties have been investigated by M. Landowsky (*Gaz. Hebdom.*, August 31, '83). He used the alcoholic extract of the bark, the administration of which in 40 minim doses, was followed by a calm sleep of twelve hours. The advantages claimed for it are, that it does not cause headache, or malaise, and does not constipate. The latest method of treating sebaceous cysts, known as Vidal's method, consists in injecting from five to ten drops of ether into the sac. The point of the needle should be moved

about after it has penetrated the tumor, so as to break up the sebaceous matter. This is to be repeated every second day until signs of inflammation appear. A puncture is then made at the base of the tumor and a small amount of pus escapes, followed by the sebaceous matter, after which the sac shrivels up and disappears. The use of caffeine in heart disease, although in use by many physicians, has not become general in this country yet. Prof. Lepine (*Lyon Médicale*) urges its use in all cases where digitalis is found valuable. He thinks the dose should be larger than has heretofore been administered. He gives from ten to thirty grains in divided doses during the day. It is much better borne and is more active than digitalis. Some attention has been paid during the year to the administration of remedies by small and frequently repeated doses, and Dr. Smith, of Bellevue Hospital, published a very interesting article on this subject in the *N. Y. Med. Journal*. The result of his experience seems to point in the direction of the efficacy of small doses often repeated, and will no doubt lead to a further trial of this plan of treatment. Paraldehyde, the new hypnotic, has been made the subject of investigation. In physiological action it strongly resembles chloral. A dose of 40 grains produces quiet refreshing sleep for from four to seven hours. It strengthens the heart's action, gives rise to no unpleasant symptoms, and it is believed that it will to a large extent take the place of chloral. A new method has been brought to the notice of the profession for the treatment of obstinate granular conjunctivitis. It consists in the application of a lotion composed of infusion of jequirity seeds, which produces ophthalmia of a croupous nature, and rapidly cures the granulations. The intensity of the inflammation can be regulated by the strength and frequency of application of the infusion.

In the field of surgery, general and operative, much progress has been made, both in the matter of perfecting well known operative procedures and in the application of new methods. The method of treating floating kidney by "fixation" has been put into practice by Dr. Newman, of Glasgow. The kidney was cut down upon, external to the outer edge of the quadratus lumborum and the organ stitched to the margins of the wound, where it formed adhesions which held it in place. The case reported was quite successful. Dr. Weir

also reports a similar case in the *N. Y. Med. Jour.* Dr. Polk, in the same issue, reports a case of nephrectomy for displaced kidney, which had caused the patient very great pain. The patient passed no urine after the operation, and died on the eleventh day. The post mortem revealed the fact that her *only* kidney had been removed. A new operation for spina bifida is reported by Dr. Mayo Robinson (*Brit. Med. Journal*, March 24, '83). The skin was dissected off and the redundant serous membrane removed. The edges of the serous membrane were then stitched together by silk sutures, and over the sac was placed a portion of periosteum from a living rabbit and the skin brought together. The result was successful. In the *Brit. Med. Journal* for August 18, '83, will be found an article by Dr. Southam, of Manchester, on the treatment of aneurism by the injection of fibrin-ferment. This substance is obtained from blood-serum by coagulating it with fifteen or twenty times its volume of strong alcohol and allowing the mixture to stand for two weeks. The coagulum is then dried, pulverized, and water added to double the original volume of the serum. It is then filtered, and the filtered solution contains the fibrin-ferment. In the case under treatment, one drachm of the fibrin-ferment was injected into the sac, pressure having been first applied above and below the aneurism and continued thirty minutes. The case was not wholly successful, but Dr. Southam suggests that in a similar case it would be well to inject a larger quantity of the ferment and to keep up the pressure for a longer period. A new method of excising the ankle-joint has been devised by Prof. Busch (*Med. Wochenschrift*), in which the joint is opened without dividing a single tendon. An incision is made from one malleolus to the other, passing under the foot instead of over the dorsum. On the sides the skin only is divided, but beneath, the incision extends to the bone. The os calcis is then sawn through from below upwards, the foot strongly flexed and the diseased bones removed. Several successful cases of amputation at the hip by Furneaux Jordan's method, which consists in dissecting out the thigh bone by a vertical incision and making a circular amputation through the soft parts, some distance down. Drs. McLaren and Marshall (*Brit. Med. Journal*) each report four cases, and Mr. Shuter (*Clin. Society*, Lond.) reports a case of sub-periosteal

amputation at the hip by Jordan's method, in which new bone was formed in the stump. A case of total excision of the sternum, for the removal of a sarcomatous tumor, is reported by Prof. Koenig, *All. Wien. Med. Zeit. (Am. Four. Med. Sciences)*. The left pleura and pericardium were opened during the operation, yet the patient made a good recovery. Dr. Savory (Lond. *Lancet*) describes a modification of Syme's amputation at the ankle-joint, which consists in opening the joint from the front, after making the preliminary incisions, and dissecting out the os calcis from above downwards, thus escaping the only difficulty in Syme's operation, viz., turning back the heel flap over the os calcis. Dr. Walker (*Brit. Med. Journal*) by a mere accident discovered the value of liquor ergotæ in the radical cure of hydrocele. He injected the liquor ergotæ (Battey's) in mistake for tincture of iodine and cured his patient. Since then he has used the remedy several times, with like success. The use of carbolic acid, as recommended by Dr. Levis, of Philadelphia, has also been advocated by several surgeons. Dr. Jonah, of Eastport, Me., has an article in the present issue on this method of treatment. Dr. R. J. Hall, of New York, has also cured five or six cases by the injection of half a drachm of the acid, and prefers it to iodine. Some attention has been paid to Wheelhouse's operation of suturing nerves in wounds, and many successful cases are reported, even after some time had elapsed. Mr. T. Holmes successfully sutured the musculo-spiral nerve five months after it had been severed. He cut down through the cicatrix, and seizing the divided ends, brought them together by catgut and fine silk sutures. Sensation and motion, which had been lost in the parts supplied by this nerve, were in great measure restored. Others have had equally favorable results, in both primary suture in recent wounds, and secondary suturing. A case of ligature of the innominate artery, for aneurism of the subclavian, was reported by Mr. Thomson, of Dublin, which appeared for a time to prove successful, but the patient died on the forty-second day, from secondary hæmorrhage. Kelly's method of reducing dislocations has justly attracted considerable attention. A full description, with illustrations, will be found in our January, '83, issue, and also in the present number. Dr. Wyeth, of New York (*N. Y. Med. Journal*),

recently performed Humphrey's operation, as described in Holmes' surgery, in amputation of the penis. After removing the organ the scrotum was transfixed, the urethra dissected out an inch and a half back and brought out in the perineum. The end was then split and stitched to the sides of the incision in the perineum. The scrotum was carried up and stitched to the integument of the pubes, covering in the stump of the penis. A new dressing for wounds, termed "wood-wool," has been introduced by Prof. Bruns (*Klin. Woch.*, 20). Pine wood shavings are reduced to a state of fine division, by being rubbed through a wire sieve, after which they are dyed and impregnated with antiseptic substances. The advantages claimed for wood-wool are that it is soft, pliable and elastic, and has extraordinary power of absorbing fluids, greatly superior in this respect to any known dressing. Quite recently, Prof. Lister has reported several cases of transverse fracture of the patella successfully treated by wiring the fragments together and inserting a drainage tube at the lower and outer part of the knee-joint. In the discussion that followed the reading of his paper, it was maintained that although this treatment was successful in Lister's hands, it would not be safe practice as a general rule. Dr. Davy, of the Westminster Hospital, has also been experimenting on the knee-joint, by way of devising a new method of resection, which he calls "tibio-femoral impaction." He forms a sort of tenon on the end of the femur, which he fits into a mortice cut in the head of the tibia. Osseous ankylosis is more rapidly obtained by this process. The immediate treatment of fractures by plaster of Paris splints has attracted some attention. Christopher Heath has given the weight of his testimony in its favor, in a paper read at the last meeting of the Brit. Med. Association. Other good authorities also bear testimony to its value in suitable cases.

Estlander's operation of excision of the ribs in a case of chronic empyema has been recently performed in the Toronto General Hospital, by Prof. Fulton, of Trinity Medical College. A portion of the 8th and 9th ribs, three inches in length, was removed, in order on the one hand, to make a larger opening for the escape of pus, and on the other, to allow of the retrocession of the chest wall at that point. The patient did well, and complete recovery is confidently anticipated. Some further

attention has been given to the important subject of anæsthetics. M. Guillot (*Progrès Medical*) gives some points in his experience of the various anæsthetic mixtures. He obtained, as many others have, good results from the a.c.e. mixture, viz., alcohol, 1 part; chloroform, 2 parts, and ether, 3 parts (a.c.e.=1, 2, 3). Subsequently he experimented with a mixture proposed by Lennox Browne, consisting of one part alcohol and two of chloroform. This he found more rapid and satisfactory than the a.c.e. mixture. In order to make the mixture more agreeable, eau de cologne was substituted for alcohol. This combination is called "chloractherine."

In the domain of obstetrics and gynecology much good work has been accomplished, and the success has been most encouraging. Lawson Tait's operation for the removal of the ovaries and Fallopian tubes has been three times successfully performed in Canada during the past year, twice by Dr. Trenholme, and once by Dr. Gardner of Montreal. Antiseptic precautions were used in all three cases, and the patients recovered without a bad symptom. The operation has also been performed by Dr. Thomas and others with successful results. The latter, who has performed it in three cases, speaks of it, however, as sometimes a very difficult and dangerous operation, by reason of the adhesions from repeated inflammations, and the quantity of inflammatory lymph by which they are sometimes surrounded. Dr. Barret, of St. Louis, (*Courier of Medicine*) proposes a new method for the treatment of laceration of the perineum. He stitches the mucous membrane of the vagina together from above downwards, and then the integument along the raphe, using no deep stitches whatever. The stitches are inserted very closely, so as to prevent any of the discharges from entering the wound. A new operation for the reduction of chronic inversion of the uterus has been performed by Dr. Brown, of Baltimore (*N. Y. Med. Journal*). It consisted in drawing down the inverted uterus as far as possible, making an incision one inch and a half in length through the posterior wall, then introducing a Sims' dilator into the cervix, and dilating it to the fullest extent. The incision in the uterus was then closed with carbolized silk-worm gut, and the fundus replaced through the dilated cervix. The patient made an excellent and rapid recovery. Solutions of corrosive subli-

mate, as in general surgery, are coming into use in antiseptic midwifery, and are found to be much more efficacious in destroying bacteria than carbolic acid. The strength used is one to one thousand parts. A feeling is setting in in certain quarters against the Porro operation as a substitute for Cæsarian section. Dr. Garrigues, of New York, (*Am. Four. Obstet.*) says if the latter operation is done with antiseptic precautions, and the uterine wound properly sutured, the result will be as good as in the Porro operation, while it does not destroy the power of procreation. He gives in minute detail the operation and after treatment of Cæsarian section. The use of iodoform in laceration of the perineum and vagina, is the subject of an interesting article by Prof. Behm, of Berlin, (*Zeit. f. Geb. &c.*) He recommends that the wound be well dried and dusted over with iodoform before and after applying the sutures, and the surface painted with iodoform collodion. The iodoform treatment of wounds has been extensively practised in Berlin for the past year or two. The treatment of post-partum hemorrhage and secondary hemorrhage after pelvic operations by the use of hot water injections, has received renewed attention. Dr. Albert Smith read a paper on this subject at the American Gynecological Society Philadelphia, in which he strongly advocated its use in these cases. When there was a tendency to post-partum hemorrhage, he advised its use immediately after the expulsion of the placenta. Dr. Goodell corroborated Dr. Smith's views, but for open wounds he said he preferred vinegar—for post-partum hemorrhage hot vinegar. Considerable discussion has taken place during the year on the best treatment of uterine fibroids. Some German authorities hold to the opinion which is endorsed by many, that only fibroids of the os and cervix, and the submucous and intraparietal, which have, by their growth, dilated the cervix, should be removed through the vagina, and that all others should either be left to medical treatment only, or be removed by laparotomy. Dr. Knowsley Thornton has operated several times for the removal of uterine fibroids and with good results except in the intra-mural forms in which all his patients (3) died. In the subperitoneal forms he removes them by laparotomy and secures the pedicle with silk ligature. In the submucous forms he treats by rapid dilatation of the cervix and immediate enucleation preceded and

followed by antiseptic irrigation. Prof. Temple, of Trinity Medical College, recently removed a large submucous uterine fibroid by enucleation, and the patient made a rapid recovery. The treatment of abortion is another subject which has been much discussed during the past year, some advising the immediate removal of the secundines, and others advocating non-interference except in urgent cases. Dr. Mundè, of New York (*Am. Four. Obstet.*) strongly urges the immediate removal in all cases, by the finger or curette, and Dr. Alloway, of Montreal, also advocates the same plan in order to avoid the danger of hemorrhage on the one hand and septicæmia on the other. Prof. Spöndly, of Zurich, (*Zeit. f. Geburt*), in a recent paper on the subject, recommends active interference in abortion. In the present issue will be found a short paper by Dr. Carson, of this city, in which the opposite course is advocated. A great many will endorse the idea that the true line of practice lies between the two extremes. Dr. Paladini, (*Gaz. Med. Ital.*) reports a case where he successfully performed hypodermic transfusion by means of a trocar and canula with an ordinary syringe. He injected about six ozs. of blood into the *subcutaneous* tissue of the abdomen, where the skin was lax. The blood was readily absorbed and no pain or inconvenience was caused. The administration of sodium salicylate to the extent of one drachm per day is strongly recommended by M. Vigar (*Glasgow Med. Four.*) in the treatment of phlegmasia alba dolens. Under this treatment the temperature fell decidedly, the pulse became slower and the œdema diminished rapidly. The important subject of puerperal fever or "metria" as it is now proposed to call it, was ably discussed at the late meeting of the British Medical Association, by Drs. Thorburn, of Manchester, Atthill, and Moore Madden. Dr. Atthill referred to the two modes of infection viz., external sources of infection, and auto-inoculation from decomposing blood-clots and portions of placenta. The former is to be combatted by attention to antiseptic measures, and the latter by the administration of ergot, after labor. As a disinfecting material, solution of corrosive sublimate would seem to be the most certain in its effects.

The various medical associations which met during the year, were most satisfactory, both in point of numbers in attendance and interest manifested.

The Provincial Medical Associations in Ontario, New Brunswick and Nova Scotia, met as usual in the months of June and July, and were successful beyond that of former years. The Canada Medical Association met at Kingston in September, under the presidency of Dr. Mullin, of Hamilton, and was a most interesting and successful gathering. Many instructive and valuable papers, besides one or two on original research, were read and discussed. Dr. Sullivan was chosen president for 1884, and the next meeting was appointed to be held in Montreal, during the meeting of the British Science Association, which takes place on the 27th of August. The meeting of the American Medical Association was held in Cleveland, in the early part of June, under the presidency of Dr. John L. Atlee, of Lancaster, Pa., and was a very successful meeting. The Association decided, among other things, upon the establishment of a weekly Medical Journal instead of the usual volume of transactions, and Dr. N. S. Davis, of Chicago, was chosen editor. The journal has appeared every week since its establishment; but it can hardly be said fully to represent as it should, the highest interests of a body such as the American Medical Association. The action of the association in coercing every delegate to sign an acknowledgement of his adhesion to the "code" was an ill-advised proceeding, and is not likely soon to be repeated. Its effect was to produce a reaction which was most injurious to the cause it was intended to promote. Dr. Flint, Sr., of New York, was chosen President and Washington selected as the next place of meeting for the first Tuesday in May, 1884. The meeting of the British Medical Association took place in Liverpool in July and August under the presidency of Dr. Waters, and was as usual the largest medical gathering in any part of the world. The intellectual part of the proceedings was fully up to the average, and the social features were of the most hospitable and brilliant character. Dr. Cuming, of Belfast was elected president, and this place chosen for the next place of meeting.

As the outcome of the difficulty between the male and female medical students in the Kingston Medical College last winter, two medical colleges for females have been inaugurated, one in Kingston and the other in Toronto. That they can both be well sustained at present is entirely out of the

question, and we hope shortly to see an amalgamation of the two institutions.

In the matter of bibliography, the following may be mentioned among some of the books which have appeared during the past year:—Electricity, Bartholow; Legal Medicine, Tidy; Rheumatism, Gout, etc. Longstreth; International Surgery, vols. II. and III., Ashhurst; Percussion Outlines, Cutter; Practice of Medicine, Palmer (Ann Arbor); Untoward Effect of Drugs, Lewin; Medical Diagnosis, Brown; Diseases of the Eye, Nettleship; Diseases of the Throat, Seiler; Histology, Satterthwaite; Chemical Analysis, Hoffman and Power; Diseases of Skin, Hyde; Gynæcology, Hart; Auscultation, Flint; Ready Reference, Dunglison; Insanity, Stearns; Fractures, Stimson; Diseases of the Eye, Wells; Anatomy, Gray; Pathology, Gilliam; Gout, etc., Fothergill; Surgery, vol. III., Agnew; U. S. Pharmacopœia; Diseases of the Male Sexual Organs, Gross; The Physician Himself, Cathell; Medical Essays, O. W. Holmes; Lectures on Fevers, Kippax; Pathological Anatomy, Ziegler; Pathology, Coats; Diseases of the Liver, Harley; Examination of Urine, Tyson; Materia Medica, Biddle; do., Bartholow; Hygiene, Parkes; Practice of Medicine, Aitken; Chemistry, Attfield; do., Bloxam; Urinary Organs, Thompson; Venereal Diseases, Bumstead and Taylor; Therapeutics, Ringer; Prescriptions (3,000), Beasley; Wounds, Gamgee; Physical Diagnosis, Bruen; Disease of the Ovaries, Tait; Index of Medicine, Carpenter; Therapeutics, Farquharson; Insanity, Buckham; Diseases of Rectum, Allingham; Sore Throat, Prosser James etc.

The following of our confrères in Canada go to swell the obituary list—Drs. J. Clarke, Oshawa; McG. Campbell, Sherbrooke, N.S.; J. Chamberlain, Frelighsburgh, Que.; J. S. Balmar, Parkhill; F. B. Going, St. Thomas; A. Moren, Halifax, N. S.; J. J. Clarke, Cape Sable, N.S.; H. Kollmyer, Montreal, Que.; W. D. Ross, Pembina; G. E. Gascoigne, Brockville; J. A. Stevenson, London; J. A. Whyte, Montreal; B. H. Leprohon, Quebec; J. Woolverton, Grimsby; B. McIver, Pembroke; J. A. Hunter, Newcastle; R. Eustace, Canso, N. S.; A. Chisholm, Alexandria; W. Scott, Montreal; J. A. Sivewright, New Westminster, B.C.; W. Rud-dick, St. Martins, N.B.; E. Rosseau, Quebec; N. McGregor, Lucknow; E. Laberge, St. Philomene; H. Shaw, Kentville, N.S.; C. East, Forest; J. B.

Campbell, Westfield, N.Y.; R. Ripley, Amherst, N. S.; T. A. Kidd, Carp.; P. May, Pine Orchard; J. A. Sewell, Quebec; S. A. Rogers, Mount Forest; De la Haye, Winnipeg; J. J. McIlhargy, Lucan; A. A. Riddell, Toronto; T. Beatty, Lambton Mills, J. Hughes, Toronto; H. E. Manwaring, St. George, Ont.; W. McGill, Oshawa; D. A. Johnston, Bridgewater; E. H. Trudel, Montreal, etc.

Among those abroad may be mentioned Paul Dubois, Pacini, Thuillier (a member of the Cholera Commission to Egypt), Geo. M. Beard (New York), George Fox (Philadelphia), Bischoff, Ranney (New York), Rand (Philadelphia), Surgeon General Barnes, Washington; VanBuren, New York; Rinecker, Wm. Farr, Von Bruns; — Mosher, Albany; Depaul; J. Marion Sims; Bence Jones; Hilton Fagge, and others.

There have been no serious epidemics at home or abroad during the year, if we may except the outbreak of cholera in Egypt. Yellow fever, which usually prevails to the south of us during hot weather, was of a milder type than in former years and did not spread as far north as is its wont in some seasons. But what with volcanic eruptions, earthquakes, and storms on sea and land there has been an appalling loss of life during the year, a loss which, from such causes far outstrips that of any former year in our recollection. The country has been very prosperous and free from those sudden calamities which, by an inscrutable providence, have been visited upon other nations. In conclusion, we wish our readers a happy new year, abundant prosperity, and the fullest enjoyment of their best desires.

INFANT MORTALITY IN OTTAWA.—The House of Bethlehem in Ottawa, under the charge of the Grey Nuns, is a home for the care of infants, the chief source of its inmates being a Lying-in-Hospital with which it is intimately connected. The official reports show the death-rate per annum to be above 88 per cent. of all admitted. A large mortality was known to occur, and the fact much commented upon by residents of the city, but no action was taken until the City Council was asked to grant a sum of money to cover the burial expenses. Before any aid was voted an investigation was ordered, and six physicians appointed to enquire into the worthiness of the charity. The

report commends the individual efforts of the attending physicians and sisters in charge, in the endeavors to attend to the wants of their little patients. The situation of the building is not considered as favorable as it might be, but their joint opinion is, that the blame must be laid on the system of dry-nursing. The two weeks of maternal nursing required by law they consider insufficient, and advise that some other method of rearing the infants be adopted. In consequence of this report, the Council has ordered the charity to be closed until it offers better means for preserving the infants' lives. Should the warning be disregarded the attention of the Legislature will be directed to the matter.

NEW METHOD OF EXCISING THE KNEE-JOINT.—Mr. Davy of the Westminster Hospital, London (*British Med. Journal*, Oct. 20,) describes a new method of excising the knee-joint. It consists in removing a rectangular wedge from the femur and tibia. A mortice is then cut in the head of the tibia, into which the femur, shaped as a tenon, is introduced, impacted and retained by pressure upon the foot. The limb is then placed in a swinging apparatus, where it is kept until recovery takes place. The term applied to this procedure is tibio-femoral impaction. It is claimed as an advantage that this procedure effectually guards against displacement during the healing process.

FRACTURE OF THE PATELLA.—Prof. Lister read a paper recently before the Medical Society of London, (*Lancet and British Med. Journal*, Nov. 3rd, '83,) in which he mentions several cases of transverse fracture of the patella, successfully treated by wiring the fragments together. He makes a longitudinal incision down to the fragments; freshens the surface when of old standing, drills the bone obliquely so as not to encroach on the cartilaginous surface, and wires them together with stout silver wire. At the end of eight weeks the wire is removed by an incision through the cicatrix. Osseous union was secured in every instance.

MARINE HOSPITAL AND QUARANTINE OFFICE.—We give below a list of medical officers attached to Marine Hospital, and Quarantine Stations in Canada:

Quebec Marine Hospital.—Dr. O. Robitaille, Commissioner; Dr. P. Wells, Sec.-Treas.; Drs.

L. Lemieux, A. Rowand and N. E. Dionne, visiting Physicians; Dr. L. Catellier, resident Physician.

New Brunswick.—Bathurst, Dr. G. M. Duncan; St. John, Dr. L. B. Bostford and W. S. Harding; Miramichi, Dr. J. Thompson; Richibucto, Dr. J. V. Doherty; St. Andrews, Dr. S. T. Gove; Sackville, Dr. L. B. Bostford.

Nova Scotia.—Arichat, Dr. V. A. Harel; Lunenburg, Dr. S. Jacobs; Liverpool, Dr. H. G. Farish; North Sydney, Dr. H. B. McPherson; Port Mulgrave, Dr. P. A. McDonald; Pictou, Dr. J. McMillan; Yarmouth, Dr. A. M. Perrin; Sydney, Dr. D. McGillvary; Tracadie (Lazaretto), Dr. A. Smith.

Prince Edward's Island.—Charlottetown, Dr. F. Taylor; Souris, Dr. Ford.

British Columbia.—Victoria, Dr. J. C. Davie; Nanaimo, Dr. D. Cluness.

Quarantine Officers.—Grosse Isle, Dr. F. Monzambert; St. John, N. B., Dr. W. S. Harding; Halifax, N. S., Dr. W. N. Wickwire; Pictou, Dr. I. Kirkwood; Sydney, Dr. W. McKay McLeod; Charlottetown, P.E.I., Dr. W. H. Hobkirk.

A PLEASANT QUININE MIXTURE.—The following is claimed by Dr. Taylor, of Gridley, Ills., to be pleasant to the taste and readily taken by children:—

R—Quinæ Sulph.,	grs. xij.
Acidi Tannici,	grs. vj.
Sod. Bicarb.,	grs. x.
Ol. Gaultheriæ,	gtt. iij.
Syr. Simp,	ad. $\frac{3}{4}$ iij.—M.

SIG.—A teaspoonful every four hours, followed by a draught of water.

Bismuth, ipecac., opium, podophyllin, or leptanin, etc., may be added to the above when required. The formula for any strength of mixture double the amount of quinine to tannic acid, and about three-fourths as much of sodium bicarbonate.

MUSIC BOXES.—We call the attention of those in search of a handsome and appropriate present to the advertisement, in another column, of C. Gautschi & Co., Philadelphia. They have on exhibition, at their sales rooms, the finest and largest display of these beautiful Swiss instruments ever shown in this country. They reproduce the most elaborate pieces of music, old and new, with brilliancy and accuracy truly surprising, with an effect so melodious and perfect as to be absolutely wonderful. These musical boxes are far superior to the ordinary instruments generally sold in this country, and need only be seen or heard, to be appreciated.

ROGERS' GROUPS.—We have just received another of these magnificent works of art, from this celebrated artist. It is a new group entitled "Neighboring Pews," and is a most beautiful representation. It reflects great credit upon the admirable taste and skill of this unique artist. The wonderful correctness of expression, and completeness and carefulness of detail, excite the admiration of all who examine these groups. A cut of the above named group will be found in another column, and is worthy of more than a passing notice. "Neighboring Pews" would make a most suitable holiday present for either old or young.

APPOINTMENTS.—Dr. A. C. Bowerman, formerly of Ontario, has been appointed Assistant-Superintendent of the State Asylum for Insane Criminals, Auburn, N.Y.

Dr. J. J. E. Maher has been appointed Dispensary Physician, New York.

Dr. Jackson, of Quebec, has been elected Dean of the Medical Faculty of Laval University; and Dr. C. Verge, Professor of Practice of Medicine, *vice* Dr. Sewell deceased. Dr. P. Wells has been appointed Professor of Materia Medica; and Dr. Brochu, Professor of Hygiene, in the same school.

Dr. H. E. Buchan has been appointed Assistant Medical Superintendent of the Toronto Lunatic Asylum. We heartily congratulate our good friend and esteemed confrère on his appointment. He is eminently qualified for the position.

APIOL IN DYSMENORRHOEA.—This remedy which has been recently introduced to the notice of the profession through French sources, has already acquired an excellent reputation as a remedy for dysmenorrhœa. Dr. Fordyce Barker, of New York, who has given it a prolonged trial, regards it as almost a specific. He gives lactate of iron and chlorate of potash three times a day, and when symptoms of menstruation begin he gives apiol in capsules night and morning. It relieves the pain, and promotes the menstrual discharge.

PERSONAL.—Dr. Stephen Lett, for ten years Assistant Medical Superintendent of the Toronto Lunatic Asylum, and who is leaving to take charge of a private asylum in Guelph, was presented with a handsome marble clock, from the officers and attendants of the asylum. Mrs. Lett also received a beautiful silver fruit dish and a cheese cover.

Dr. Lett carries with him the good wishes of Dr. Clark, the medical superintendent, and officers of the institution, as well as the members of the profession in this city.

NEW REMEDY FOR NEURALGIA.—The latest remedy for the relief of neuralgia, says the *London Lancet*, is hyperosmic acid. It is administered hypodermically in the strength of one per cent. solution of the acid. Billroth injected the above remedy, between the tuber-ischii and trochanter, in a case of chronic sciatica, and within a day or two the pain was relieved and eventually disappeared.

MEDICAL EXAMINERS, TORONTO UNIVERSITY.—Prof. Sheard, of Trinity Medical College, Toronto, has been appointed examiner in Physiology and Pathology in the Toronto University, and Dr. Cascaden, of Iona, examiner in Surgery and Surgical Anatomy. The examiners in the other branches are the same as those on the list of last year.

FRACTURE OF THE NECK OF THE FEMUR.—Prof. Bezzi, (*Presse Med. Belge*, July 29, '83,) regards flaccidity of the tensor vaginae femoris and gluteus medius muscles, as pathognomonic of fracture of the neck of the femur. Instead of the usual resistance, there is found, when this injury has occurred, a deep depression, between the trochanter and the crest of the ilium, due to diminution of the tension of these muscles.

SULPHO-CARBOLATE OF SODA IN RHEUMATIC FEVER.—Dr. Greenway, of Plymouth, recommends the sulpho-carbolate of soda very highly in the treatment of rheumatic fever. For adults he prescribes fifteen grains every six hours in an ounce and a half of water. Ordinary precautions of administering an occasional aperient, placing the patient between blankets, and keeping him on milk diet must not be neglected.

QUACKERY.—Larrabee says: "Quackery consists in this: that while with the regular scientific physicians all things are held in common, all truths are shared, quacks, by conspicuous words and advertisements lead the people to believe that they possess ideas not known to the regular profession, and this alone is their hold upon the people whereby they gain a livelihood.

BARONETCIES.—Mr. Lister, of King's College, London, the originator of antiseptic treatment of wounds, has received a Baronetcy. A Baronetcy has also been conferred upon Dr. Andrew Clark, the distinguished physician who accompanied the Princess Louise and Marquis of Lorne to Canada in 1878. Mr. Wm. Bowman, the celebrated oculist has also been created a Baronet.

Professors Bartholow and Da Costa agree that an antipyretic dose of quinine is not less than five grains every two hours until four doses are taken, or else thirty grains in two or three doses close together. The former believes a small dose of morphine is the best thing to counteract the unpleasant cerebral symptoms of quinine.

THE U. S. PHARMACOPŒIA.—Any person having a copy of the U. S. Pharmacopœia of 1880, and desiring a list of the corrections since made therein, can procure the same by sending a two cent stamp to Wm. Wood & Co., publishers, N.Y.

A case of chorea which resisted all other remedies, was shown recently, at the medical clinic of Prof. Da Costa, cured by hyoscyamine. The drug was given *ter die*, in doses sufficient to produce very slight characteristic effects, beginning with gr. $\frac{1}{100}$.

THE FORCE OF HABIT.—Missus (*who is acting as amanuensis to Mary*)—"Is there anything more you wish me to say, Mary? Mary—"No, marm except just to say, please excuse bad writin' and spellin'".—*Punch*.

BRITISH DIPLOMAS.—Drs. W. Hanbridge, M.D. (Trinity), and W. H. Oliphant, M.D. (Toronto) have received the license of King's and Queen's College, Dublin.

REMOVALS.—Dr. J. W. Ray has removed from Dunsford to Cambray, Ont. Dr. Holmes, of Toronto, has removed to Brussels.

CORONER.—Dr. Henry E. Gillmor has been appointed coroner for the city and county of St. John, N. B.

The death of Dr. Hilton Fagge, at the early age of 46 years, is announced in our British exchange.

New Instruments.

DR. RYERSON'S IMPROVED NASAL DOUCHE.—

The advantages claimed for the improved douche are as follows :



1. It can be used for douching the nasal passages both from the posterior and anterior openings. The latter is used by detaching the injector from the hard rubber post-nasal piece.

2. When the douche is once in place posteriorly it is not necessary to remove it until the amount of fluid necessary has been used. With the ordinary post-nasal douches the instrument must be re-introduced for each bulbful.

3. Owing to the upward curve of the external portion of the post-nasal tube, the hands are removed out of the way of the returning fluid. Most douches curve downward and the fluid frequently runs up the sleeve.

4. Being made of English black rubber, of good quality, it lasts well, as it is not so easily destroyed by solutions as is white rubber.

Made at Dr. Ryerson's suggestion by Stevens & Son, London and Toronto. The douches have been in use for 18 months and have answered the requirements exceedingly well.

Books and Pamphlets.

INSANITY CONSIDERED IN ITS MEDICO-LEGAL RELATIONS, by J. R. Buckham, A.M., M.D., Flint, Mich. Philadelphia: J. B. Lippincott & Co. London, 16 Southampton-st., Strand, pp. 250.

The object the author had before him in preparing this most excellent work was to draw attention to the uncertainty of verdicts in insanity trials, and the more prominent causes of that uncertainty. The author points out the absurdity of many of

the decisions of the courts of law, and shows that the rulings have been as various as the forms of insanity itself. He treats of expert testimony in a way which is not only just and impartial, but also rational and comprehensive. Experts in insanity, he very properly maintains, are those only who have devoted a life-time to the study and investigation of this subject, and that physicians in general have no claim whatever to be considered experts.

In this position we believe the author is perfectly correct, and fully justified in his proposition that the giving of expert testimony in insanity cases should either be put upon some rational basis, or entirely abandoned. He recommends that only skilled men should be appointed as superintendents of asylums, and only those so qualified, who have been in the active discharge of the duties of such positions, for a period of at least — years, shall be eligible to testify as experts in insanity in any court. They shall give testimony when required as a part of their duty, without remuneration as witnesses. The expert should be considered as *amicus curiæ*, and as such, should be subpoenaed not on behalf of "the defence" or "the prosecution", but on behalf of the court. The author also justly attaches great importance to the opportunity of observing the supposed lunatic for a sufficient length of time, and particularly when the subject considers himself free from observation. The above plan, under certain modifications, which experience would suggest, seems to us to afford the ground-work of a most necessary medico-legal reform. We heartily commend the work to the attention of our readers.

THE TREATMENT OF WOUNDS. By Louis S. Pilcher, A.M., M.D., Member of the New York Surgical Society. New York: Wm. Wood & Co. 1883.

This work of 378 pages deals in a very practical way with the treatment of wounds. The first two chapters treat of wounds in general, repair, etc. Chapter III. treats of "The Relations of Micro-organisms to Wound Disturbances." Chapter IV., "Asepsis and Antiseptics—Wound Cleanliness." Chapter V., "Wound Disinfection—Antiseptics," etc., etc. As a germicide the author gives special prominence to corrosive sublimate, and states that a solution of the strength of one to 500 is a harmless dressing for wounds. With regard to abdominal wounds involving the viscera, he states that "the duty of the surgeon is *clearly* to enlarge the opening in the abdominal wall, or to make a new one in a more favorable location, sufficiently to admit of examination of the viscera in the track of the wound, to detect and ligate bleeding vessels,

to suture intestinal rents, and to thoroughly cleanse the peritoneal cavity of extravasated matters."

MANUAL OF PATHOLOGY. By Joseph Coats, M.D., Lecturer on Pathology in the Western Infirmary, Glasgow, etc.; with 339 Illustrations. Philadelphia: H. C. Lea's Son & Co. Toronto: Vannevar & Co.

The scope of the work before us is somewhat more extensive than that of most works on the subject, including as it does both pathological anatomy and general pathology, while most works are limited to one or other of these subjects. As the author has been engaged in teaching, and in practical work connected with these subjects for the past fourteen years, the work cannot fail coming from such an authority as Dr. Coats, to be of scientific and practical value to all students of pathology, old and young. The work supplies a real want, long felt, and the profession are under the deepest obligation to the author for having undertaken the publication of this most excellent manual. The work is divided into two parts. The first part deals with general diseases, and treats exhaustively affections of the circulation of the blood, inflammation, and the various tissue changes wrought by diseased conditions of a general character. The second part takes up, also very fully, the diseases of special organs and system. Such a book was needed at this time, when pathology is making such strides, and the subject is perhaps one of the most interesting, and certainly one of the most useful departments of study. We heartily commend the book to our readers who desire to be abreast of the day in pathological knowledge.

MEDICAL EDUCATION AND THE REGULATION OF THE PRACTICE OF MEDICINE IN THE UNITED STATES AND CANADA. Published by the Illinois Board of Health, 1883.

This work is the outcome of steps which were taken by the Board to determine the good standing of medical colleges in the United States and Canada; a college directory of each State is given, and also a list of colleges not recognized by the Board. In a summary given at the end of the directory, the total number of medical men in the United States and Canada is stated at 90,410, which gives a proportion to population of about 1 to 600—the number of physicians in Canada being 3,487, proportion to population 1 to 1,112. The Medical Act in force in the different provinces in Canada and the States of the Union are given in detail. The work will therefore prove very useful for reference by members of the profession

interested in such matters. Our friends of the Women's Medical College, Toronto, will be a little worried to find their college set down as (Homœopathic).

CHEMISTRY, GENERAL, MEDICAL AND PHARMACEUTICAL, by John Attfield, F.R.S., Prof of Practical Chemistry to the Pharmaceutical Society of Great Britain. Tenth edition, revised by the author. Philadelphia: H. C. Lea's Son & Co. Toronto: Vannevar & Co.

This work is so well and favourably known as not to require more than a mere passing notice at our hands. The present edition contains such alterations and editions as seemed necessary for the demonstration of the latest developments of chemical principles, and the latest application of chemistry in pharmacy. It includes the chemistry of the United States pharmacopœia, and nearly all of the chemistry of the British and Indian pharmacopœias. The index contains eight thousand references.

THE PHYSICIAN'S POCKET DAY-BOOK for 1884, by C. Henri Leonard, M.A., M.D., Detroit, Mich. Price, \$1.00.

This is the smallest and most compact list published. It is arranged so as to record the daily visits to twenty or forty patients per week, besides obstetrical record, monthly memoranda, cash acct, etc. It is very light, of convenient size to carry in the pocket, and is not encumbered with memoranda, tables, etc., which every well-informed physician should have at command.

THE MEDICAL RECORD VISITING LIST for 1884, by Wm. Wood & Co., New York. Price, \$1.50.

This is the handsomest physician's list in the market. It is also of convenient size, all unnecessary text having been omitted in order to make it more compact and concise. It is arranged for 30 or 60 patients, and the ruling under the various headings will be found most convenient and practical.

Births, Marriages and Deaths.

In this city, on the 15th ult., Dr. A. A. Riddel, aged 64 years.

In this city, on the 16th ult., Dr. J. H. Hughes, aged 45 years.

At Bridgewater, Ont., on the 21st September D. A. Johnston, M.D., aged 26 years.

On the 25th ult., Dr. T. Beatty, of Lambton Mills, aged 57 years.

THE CANADA LANCET.

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CRITICISM AND NEWS.

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Original Communications.

ANGEL-WING DEFORMITY.

BY THOS. R. DUPUIS, M.D., ETC., KINGSTON, ONT.

This is a peculiar affection which, on account of its rarity, is more of a curiosity than otherwise. In the course of twenty-five years' practice I have met with three cases of it, and all of these have occurred within the last seven years. I also heard of another case from the first patient I saw with it. He stated to me that an acquaintance of his was similarly affected and that he obtained relief by wearing a strap around his shoulders in such a manner as to keep a pad firmly pressed against the posterior surface of the shoulder-blade. The deformity is easily recognized, once its prominent features are known; but since so few authors have noticed it in their writings, a patient afflicted with it might easily pass under review without its being detected—the pain and weakness of the shoulder being referred to a sprain or bruise or to a rheumatic affection. To give such a short account of it as may refresh the minds of some of the readers of your widely circulated journal, is my object in detailing the following particulars.

The disease usually commences by pains in the shoulder and upper part of the arm, at the root of the neck, above the scapula or immediately beneath it; the pains may be of an intense darting neuralgic character, or dull and aching so as to produce a tired sensation rather than acute pain. Neuralgic pain may co-exist in other parts of the body. Loss of power in the parts and inability to sustain prolonged exertion with the arm and shoulder, gradually make their appearance. When the patient's arms are held loosely by his or her side, very little deviation from the normal can be seen. By close inspection, however, the inferior angle of

the scapula on the affected side may be found somewhat nearer to the mesial line than the other one, the vertebral border traced from below upwards thus assuming a direction more outwards than natural, and the lower angle of the scapula may also be a little too far from the chest-wall. When the patient attempts to raise the arm, all these deviations are exaggerated and can be readily and distinctly seen. The arm can be raised voluntarily only to the horizontal position, and while this is being done the vertebral border of the scapula rotates outwards in such a manner that the anterior surface of the bone forms nearly a right angle with the wall of the chest. This leaves a very large and deep hollow between the thorax and the scapula, and thus exhibits that peculiar outstanding condition of its posterior border which has given this deformity the distinctive name of "angel-wing." Faradic reaction is lost and galvanic excitability greatly diminished in the paralyzed muscles. In long standing cases, atrophy of the muscles supervenes. This disease may be from two weeks to two months from the beginning of the pains till loss of power in the parts and the full characteristic symptoms manifest themselves, and it has an indefinite duration.

This disease usually occurs in weakly young persons, and may result from injury or overwork (and hence is more common in males and on the right side of the body), from direct injuries to the nerves, from falls, blows, wounds, carrying heavy weights upon the shoulder, from rheumatic influences contracted by sitting in draughts, or exposure to wet; and even the syphilitic poison has been suspected as a cause. In my first case, the patient was a loosely made, rapidly growing farmer's son, about 18 years of age, in whom the disease was directly traceable to hoeing, having been a long time engaged in hoeing potatoes and corn. In my last, the subject was a delicately formed young lady, of nervous and excitable temperament, who had overdone herself by long hours and intense application at some fancy needlework which she was anxious to have completed within a given time.

Putzel says, "quite an extensive journal literature has been published on the subject, but as the paralysis which produces the affection is of comparatively rare occurrence, its real cause remains undecided." He further remarks that it is usually unilateral, and that the large majority of cases have

been observed upon the right side. In the three cases which I have seen, the first was upon the right side, and the last on the left side; but I cannot now remember on which side the second was. The same author gives this disease the pathological name of Paralysis of the Serratus Magnus; but I refrain for the present from giving it other than the synonym heading this article, as its real pathology does not seem to be entirely agreed upon.

By consulting authors, I have found several notices of this affection, the descriptions of it varying somewhat in each; and by two, at least, the disease formerly supposed to be "dislocation of the lower angle of the scapula over the latissimus dorsi muscle," is considered as a part of this affection.

In the "System of Surgery," edited by T. Holmes, second edition, vol. ii, p. 757, the following occurs in a note following sprain about the shoulder: "In connection with this subject a curious injury may be mentioned, which has been described as displacement of the inferior angle of the scapula over the edge of the latissimus dorsi muscle. . . ." Then follows the report of three cases, being all that the writer had been able to collate of *anything analogous to this*, and none of these, he says, did "exactly correspond with the description given by Liston; for although the posterior border and inferior angle of the scapula projected very markedly, there was no distinct account of any injury, and the affection seemed rather to be *paralysis of the muscles* attached to this part of the bone, especially the serratus magnus." "In the last mentioned case," he continues, "the subject was a delicate looking girl of fourteen; the whole of the posterior border of the right scapula was very prominent, and seemed to meet the skin covering it almost at a right angle. The inferior angle projected only a little more than the rest of the border, but the fingers could be passed fairly beneath it. The scapula could easily be pressed into the proper position, but it immediately started back again when left to itself. The motion of the arm was weakened and impaired." The writer further on states as follows: "I have seen a few similar cases. In all, the projection of the lower angle of the scapula was apparently due to atony of the muscles attached to the vertebral border of the bone, and in no instance was there a history of any antecedent injury."

Professor Gross describes a mal-position of the scapula, which he thinks arises from paralysis of the rhomboid muscles, and which, in its semeiology, evidently agrees with the disease under consideration; he holds also that that condition termed dislocation of the scapula, in which the inferior angle is supposed to lie upon, instead of beneath the latissimus dorsi, is frequently of a similar nature and depends upon relaxation of the muscles. Excepting that form of dislocation which depends upon direct injury, the fact seems to be that the "dislocation of the scapula" of the older authors, the affection referred by Gross to paralysis of the rhomboid muscles, and the "angel-wing deformity," supposed by Putzel to depend upon paralysis of the serratus magnus, are varying phases of the same disease.

What then is the true pathology of these abnormal conditions of the scapula? Gross inclines to the view that the chief trouble is paralysis of the rhomboid muscles, the writer in "Holmes' System" that the serratus magnus is implicated as well; and a late case exhibited before the clinical section of the Birmingham and Midland Counties Pathological Society, Nov. 30th, 1883, elicited the following opinions: "Mr. W. F. Haslam showed a patient with an affection of the scapular muscles, which allowed the right scapula to project from the thoracic wall when the shoulders were thrown back. The right acromion was depressed, and the arm could not be raised much above the shoulder. He thought the condition due to paralysis of the trapezius. Mr. Jordan Lloyd believed the rhomboidei were the muscles most in fault. Mr. Bennett May thought the serratus magnus was the muscle paralyzed, and that the lower end of the scapula had slipped from under the latissimus dorsi."—*Brit. Med. Jour.*, Dec. 8, '83.

I have inserted this case here to illustrate the obscurity in which the true pathology of this affection is shrouded. My own opinion is, that the serratus magnus and the rhomboidei muscles must all be more or less paralyzed, to produce the affection in its fully developed state. Paralysis of the serratus magnus alone, while it would permit the vertebral border of the scapula to recede from the thoracic wall, could not produce that outstanding condition of this border of the scapula so characteristic of this affection, because the rhomboideus major and minor would resist it; and not only

would they resist it, but from their obliquely downward and outward course they would pull the lower angle of the scapula upwards and inwards, and cause the vertebral border to assume a direction very obliquely upwards and outwards from the mesial line of the back. This direction of the vertebral border is not decidedly marked; hence it follows that the rhomboidei must also have lost their contractile power. Now paralysis of the serratus and rhomboids together would produce the condition of parts we are considering, while the trapezius and levator anguli scapulæ still retained their power; the first of these holding the scapula in place laterally and preventing rotation downwards and forwards; the latter holding the scapula up and preventing it from sinking down perpendicularly along the side. If we examine the origin of the nerves supplying these muscles attached to the scapula, we may arrive at a better understanding of the lesions that are present. The trapezius is supplied chiefly by the spinal accessory, but receives communications from the cervical plexus; this therefore may be laid aside for present purposes. The levator anguli scapulæ is supplied chiefly by branches from the cervical plexus; but the cervical plexus is formed by the anterior branches of the four upper cervical nerves, and is therefore above the source of nerve-supply for the serratus magnus and rhomboidei. The rhomboid muscles and serratus magnus are supplied by branches from the 5th and 6th cervical, the rhomboid branches being from the 5th alone, and that to the serratus—the posterior thoracic—from both the 5th and 6th. It is quite reasonable to suppose that if the cause of paralysis existed at the roots of the nerve to the serratus magnus, the nerves to the rhomboidei also, which arise with one of the roots of the foregoing, would suffer, and we ought to have paralysis of the rhomboidei co-existing with paralysis of the serratus magnus. Putzel, although he refers it to paralysis of this last muscle alone, very judiciously adds, "The other muscles of the scapula and shoulder should also be carefully examined, as we not infrequently find that the same cause which has produced the affection under consideration, has also given rise to paralysis of some of the other adjacent muscles." We are therefore forced to the conclusion that "angel-wing deformity" is due to paralysis, more or less complete, of the serratus magnus and the two rhomboids, and that the projection of the

lower angle of the scapula heretofore described as "dislocation over the latissimus dorsi," is due to the relaxed condition of the muscles that hold the scapula in place, and is not an independent affection. Of course the paralysis may not stop here, but other muscles of the shoulder may become implicated, according to the gravity of the cause producing the injury to the nerves; but for the production of the affection under consideration paralysis of the three muscles stated is sufficient, and all of these, I hold, must be involved to produce a typical case.

A few words with respect to the treatment of this disease may not be out of place. As the subjects of it are generally weakly and ill-nourished of over-worked young persons, the first great object is to improve the general condition of the patient. Fresh air, gentle exercise, good diet, with the use of the shower bath or salt-water bathing, friction over the body, chalybeate tonics, nux-vomica, and such other remedies as adapt themselves to the circumstances of the patient. Putzel, from whose work I have already quoted, recommends electricity as the great means of cure. One electrode should be placed over the roots of the affected nerves (on the neck, above the clavicle) and the other over their distribution, as in the axilla, along the origins of the serratus magnus, or behind the chest, between it and the outstanding scapula. Counter-irritation, if there is pain, and the use of morphia when urgently demanded. Many other means will readily suggest themselves to the attendant physician, once he is fully satisfied as to the pathology and etiology of the disease.

DANGER OF THE PARASITIC THEORIES.

BY JOSEPH WORKMAN, M.D., TORONTO.

Audi alterum partem.

The September number of the *Gazeta Medica da Bahia*, contains an article by Dr. Jousset de Belesme, on the subject of the "Danger of the Parasitic Theories," which may not perhaps, at the present time, when there seems to be so strong a tendency in the medical world to rush into premature etiological conclusions, be altogether unprofitable, for, whether the parasitic theory of infectious diseases ultimately proves to be correct, or the contrary, a free exposition, alike of its

merits and its defects, will be the best means of settling the question. We therefore present the following translation from the Portuguese, of the article alluded to :

"We have not been the last to speak against the application of the theory of the microbes in medicine, and to ascribe to it those great inconveniences which the acceptance of these doctrines may introduce into pathology. When we wrote that these theories, almost totally hypothetical, were leading medicine into a bad path, in attributing to morbid phenomenon a simplicity which it is far from possessing, and conducting to irrational means of treatment, which were dangerous to patients, we were accused of exaggeration and prejudice, whilst we were but echoing the convictions of a great number of clinicians, and it was the fact that a manifest reaction has arisen against these tendencies, among French pathologists. Those physicians who employ remedies impartially, or, so to say, in an experimental way, have evidently accepted the theories of Pasteur, under the hope of obtaining advantages from them in their treatment of diseases ; in no other way can we explain the progress of the parasitic doctrine and the rather premature haste with which it has been accepted, chiefly by the younger members of the profession. So very important is it to vanquish a disease, or to discover its cause, and so positive has Pasteur been, that a good many physicians have judged, that if it is the fact that infectious diseases are caused by microbes, to kill these parasites is to cure the patient.

All practitioners who reason thus, forget just one thing, as does Pasteur, which however should be taken into consideration ; and this is, *the patient*. Yes, there is, unfortunately, a patient in the question of the microbes, as regards pathology. The matter is not so simple as it is in the laboratory, in which if a microbe is put into a bottle to multiply, and to exhaust the strength of a quantity of chicken broth, no more is then required than to add some powerful poison, the most energetic of the antiseptics, and everything disappears, everything, if we believe Pasteur, except the germs of these singular vegetables. But when we have in hands a patient however filled, he may be supposed to be with microbes, we cannot treat him as we do the chicken broth, with strong antiseptics. Some physicians have done this, and Mons. Jaccoud,

whose great ability no person contests, has shown us in his recently published lectures on the treatment of typhoid fever, the result of these bold attempts. In the statistics of mortality of typhoid fever, the employment of antiseptics, in large doses, has introduced an element which previously figured very exceptionally—*sudden death*.

It is beyond doubt that setting out from the preconceived idea that typhoid fever results from the development of microbes in the economy, physicians have been forcibly led to employ antiseptics. Recourse is had to those which are most tolerable to the organism, as salicylic acid, sulphate of quinine, carbolic acid. As the administration of these medicines in small doses produces no result, logic demands that the doses shall be increased until the troublesome microbe is annihilated ; as has already been said, the patient is forgotten, but he, in his turn, when the dose is sufficient, does not forget to die suddenly. Sudden death is, I know, one of the results which may be introduced into the art of curing by the discoveries of Pasteur. When we reflect on these facts we must regard it as extraordinary, that doctrines leading to such results have been able to gain the vogue in medical practice, in which the practitioner has certainly no interest in losing his clients.

But granting that the theories of Pasteur are correct, and that typhoid fever is in reality the product of an invasion of microbes, evidently no result profitable to therapeutics can be derived from the knowledge of this fact, for the simple reason, that the organism does not tolerate doses of antiseptics sufficient to kill, in the blood, or in the middle of our tissues, inferior parasitic organisms, whose resistance to these agents is greater than that of the cells of our economy, which are differentiated in a far higher degree. To believe that we can find an antiseptic capable of destroying bacteria, and leaving uninjured the histological elements of man, is but to seek to be deluded, and to ignore the laws of general physiology. The more differentiated an organism is, the less resistance does it oppose to the external agents capable of injuring it ; consequently it may be affirmed, that of all the organic cells, the bacteria are perhaps the most resistant of the action of toxic and antiseptic substances. Be this as it may, it is beyond doubt that typhoid patients, to whom anti-

septics are administered in high doses, die suddenly, and even the sulphate of quinine is not an exception to this rule.

For this reason Mons. Jaccoud has risen with vehemence, in his lectures, against these therapeutic temerities. "I regard it, writes this eminent Professor," as a duty to be fulfilled; and to condemn these with all my strength I must point out to you the therapeutic excesses which for many years have been committed in the treatment of typhoid fever. In the commencement, the excess set out with the false idea that the fever is the unique element of the disease. The evil was aggravated when they desired, without any solid reason, to apply to typhoid fever the bacterian theories, and this anti-parasitic phase was the signal for a true therapeutic unchaining; they were not content with raising beyond the usual limits the doses of the antiseptics, which are at the same time parasitocides, but they also accumulated them all in potent association; if they would, with more certainty, reach the supreme end, they must first of all kill the microbio.

Well then, gentlemen, suppose that you have in hand a disease which *per se*, directly threatens the heart, the brain, and the kidneys, would you add to these dangers those of an association of quinine salicylic acid and carbolic acid, in which each of these agents figures in high doses? Those vagaries which are the fruit of the spirit of system, are no novelty. What have we seen in our own era, in the time of Rasori? They then sought to liberate the diathesis from stimulus, and they killed the pneumonics; in the time of Broussais they abstracted the irritation, and along with it the patient.

The cry of alarm is neither excessive nor premature, for so far as we can see, in every part of Europe patients attacked with typhoid fever have suffered from theory one or other of the medicinal aggressions which I have mentioned. I entreat you to abstain from similar audacities, and to leave every question on its true basis; repel all premature applications which are the offspring of pathology (?) or of animal experimentation; whatever may be the role the future may assign to the microbio, never, in the diseases of man, lose sight of your *patient*, who is its carrier; do not forget that you cannot reach this enemy unless through the intervention of the patient, and the tolerance of

the latter is the unique and true measure for therapeutic interference. But granting, for the moment, the reality of the hypothesis, that the cure of typhoid fever depends on the death of the microbes, does the treatment required for their destruction exceed the resistance of the patient? See here, gentlemen, the principles you should ever keep clearly in view; they will be your safe guide in your practice; with them you will be able profitably to resist the exclusive tendencies, exaggeration and danger I have pointed out."

URÆMIC POISONING FOLLOWING SUPPRESSION OF URINE IN A FEMALE AFTER LABOR.

BY R. M'CREA, M.D., LAKEVILLE, N.B.

I send you the following notes of a case in the hope that some of your numerous readers will give a diagnosis with the causation of disease.

On the evening of the 17th of October, I was called to attend Mrs. T. in her third confinement. I had attended her in the two previous confinements, the first being a living child, the second still-born at the eighth month. The following are the bedside notes of the case. The present confinement also occurred at the eighth month; fœtus still-born; placenta and fœtus slightly decomposed; after delivery she complained of pain in the lumbar region, for which I ordered a Dover's powder and left.

18th.—Called again; the patient was still suffering marked sharp and constant pain in the lumbar region. Pulse natural; temp. 99°. Ordered half a drachm of tr. opium in starch enema. In about half an hour the pain ceased. She has not passed any urine since confinement. Ordered tincture of digitalis and spts. eth. nit. every two hours.

19th.—Has not passed any urine; pain has not returned; vomiting; passed catheter, no urine in bladder; pulse 86; temp. 100. Ordered thirty grains of compound jalap powder.

20th.—Patient restless; pupils contracted; no pain. Gave alkalies, diuretics and diaphoretics.

21st.—Patient same in all respects; temp. 101; pulse 120; resp. normal; met another practitioner in consultation. He recommended a discontinuance of the alkalies, and suggested tr. ferri mur.

22nd.—Pulse 101; temp. 102; slight clonic

spasms ; headache ; slight perspiration ; complains of soreness in the bowels and tenesmus of the bladder. There were also passive delirium ; vomiting, hiccough and contracted pupils.

23rd.—Pulse 92 ; temp. 99 ; vomiting ; hiccough ; tenesmus of the bladder ; bowels acted loosely without control ; pupils still contracted ; patient evidently sinking ; passed catheter, no urine.

24th.—Pulse 120 ; temp. 103 ; vomiting ; no hiccough ; sinking ; appears to be somnolent and listless ; unchanged in other respects.

25th.—Pulse 118 ; temp. 101 ; resp. 12 ; breath fetid and ammoniacal ; somnolent ; clonic spasms ; perspired freely from diaphoretic.

26th.—Restless ; delirious ; lies with mouth open ; answers questions with hesitation ; passed catheter, no urine ; condition in other respects much the same.

27th.—Pulse 116 ; temp. 101 ; resp. 8 ; lies in a comatose condition ; took no nourishment ; condition in other respects unchanged. She died at 12 o'clock at night.

The points of interest to me in this case are the following :—

1st. The sudden suppression of urine without any previous history of kidney trouble.

2nd. The length of time that the system withstood the suppression, viz., eleven days.

3rd. As to the cause, which was in all probability due to the absorption of decomposing matter in connection with the dead foetus in the womb, producing blood-poisoning. Of this, I think there can be very little doubt, as the symptoms point strongly to such a condition.

[Apropos of the above case, Dr. McLaren, of Delaware, Ont., sends us brief notes of a case recently, where a woman, æt. 51, lived for 17½ days, without passing urine, and died from uræmic poisoning. Just before this condition set in she had, for about thirty hours, suffered from an attack of hæmaturia. That ceasing, no further urine was secreted—*entire suppression*. The patient had been an invalid for seven years. The Dr. has promised us full notes of the case later on].—ED. LANCET.

Correspondence.

EXTRAORDINARY TESTIMONY.

To the Editor of the CANADA LANCET.

SIR,—Would you be kind enough to give your

readers a definition of what is really comprehended in a medical visit? In a recent case in the county court in this Province, one witness gave extraordinary testimony, which was published in the *Examiner* newspaper, as follows :—“I define it to be what you do after you get there; it may be to draw a tooth—it may be a case of midwifery ; I would include six hours in a visit ; twenty minutes or half an hour is long enough for a consultation ; when one doctor sends for another, he does it to learn something or share responsibility, and has no right to be paid ; but the one sent for should be paid ; a doctor has no right to receive so much for removing a placenta as a case of midwifery, for removing a placenta is a minor part of it ; I never charge more than a dollar for it ; administering an enema is one of those things that old women do ; the services performed at the house is the main consideration for making a charge.” As the privileges of medical men in the courts here depend very much on the medical testimony available at the court, and finding medical jurisprudence not generally viewed by witnesses from the same standpoint, would you be kind enough to give us your experience of the practice and custom of the profession in Ontario, as well as the treatment medical men receive in the courts? I thought a medical visit included nothing more than going to the patient, making a diagnosis, and prescribing. What is your custom and practice? Does a visit include or comprehend any operation? Do your courts of justice require medical men to analyze their prescriptions item by item in proving the value of the medicines furnished, by reading each item to the judge, or would it be sufficient to call testimony, and submit the prescription, and ask the witness to prove its value? Have you a scale of fees for medical men in the Province of Ontario, and what weight does such scale of fees carry in your courts? What would you consider a reasonable fee for administering an enema? Is it customary to charge for detention, and how much per hour? Would five dollars be a reasonable fee for removing an adherent placenta in a case of abortion or premature birth?

I always thought, when a doctor took charge of a case that he could visit the patient as often as he thought proper without having fresh authority each time he visited ; and that the medical man having charge of the case was allowed discretionary powers,

as his visits could not be pre-determined. The medical man is the only proper judge of the necessities of the patient, and I should think he could exercise his discretion accordingly and be entitled to his ordinary and customary fees for each visit. I have been taught that consultations were for the benefit of the patient, and consequently the patient should pay the consultant. I also thought that charges upon a physician's bill for "visits and medicines" were sufficiently specific, although the *quality* and *quantity* of the medicines be not designated.

Yours truly,

A PRACTITIONER.

P. E. Island, 27th Dec., 1883.

[An ordinary visit does not include any operative procedure except of the most trivial character. Some of our judges require medical men who supply their own medicine and thereby act as druggists, to detail every item in the bill; others do not. There is no schedule of fees for this Province, but in most of the city and district societies a regular tariff is established, and this is recognised in the courts. The usual charge for detention after the first hour, and in confinements after six hours, is from \$1 to \$4 per hour. Five dollars would be a reasonable charge for removing an adherent placenta. It is generally conceded that the attending physician is the best judge as to the number and frequency of his visits. Consultations are for the benefit of the patient, or to satisfy the whims of friends or relatives, and are always paid by the patient or his friends—never by the attending physician.]—ED. LANCET.

QUADRUPLETS.

To the Editor of the CANADA LANCET.

SIR,—I send you a few notes of a somewhat rare case of midwifery, which recently occurred in this vicinity, thinking they might be of interest to your readers.

On Dec. 17th, 1883, I saw Mrs. H. Multipara, who on Dec. 12th was delivered of four (4) living male children, one of which only lived two (2) hours. She was attended by a midwife, and I was informed that the labor was short and easy. The presentations were all "breech", and each child had a distinct and separate placenta. There was no hæmorrhage, and convalescence has been nor-

mal, with the exception of a bad back-ache, relieved by a belladonna plaster. From the appearance of the children, as well as from the mother's calculation, I judged labor had taken place at about the middle of the (8th) eighth month of gestation. The boys were small, averaging perhaps $2\frac{1}{2}$ lbs., but were perfectly formed, and performed all their functions in a normal manner. On Dec. 30th, I was called to see them, and found they had taken cold, and were suffering from what was apparently bronchitis, from which they all died in less than 48 hours.

Yours truly,

G. H. COBURN.

Fredericton, N.B., Jan. 11, '83.

Reports of Societies.

ST. JOHN, N.B., MEDICAL SOCIETY.

Jan. 3rd, 1883.

Dr. Hetherington reported a case of poisoning by Barbados tar. The patient, a young man of 30 years, was troubled with hemorrhoids, and on the strength of a friend's advice he purchased 4 ozs. of Barbados tar, taking a tablespoonful as a first dose; in two hours he was in the most excruciating pain from the hypogastric region down through the bowels, and continued through the thighs and legs. He described the pains as "cutting cramps"; he also vomited considerably. I watched him a very few minutes and saw that he was rapidly growing worse. I gave him $\frac{1}{2}$ grain of morphia hypodermically, and in a short time he was free from pain. The next day he felt very sore and weak, but made a rapid recovery.

Dr. T. Walker reported a case of extraordinary high temperature, nine days after parturition, treated with 5 gr. doses of quinine, every 3 hours, with very satisfactory results. Dr. Musgrove thought these were not cases of puerperal fever. Dr. J. Christie treated such cases with opiates.

Dr. Musgrove showed 4 ozs. of fluid taken from a knee joint with an aspirator, at two operations, with an interval of 13 days, after which it did not return, but resulted in recovery. He approved of early removal of fluid.

Dr. Coleman showed a patient, æt 21, from whose left eye he had extracted a cataract and enucleated the stump of the right. The right eye

had been lost for 14 years. The sight of the left began to fail ten years ago, and was soon lost, probably from sympathetic iritis. In July last a downward iridectomy was done at the Massachusetts Eye Infirmary, but no improvement. As a last resort Dr. Coleman extracted the lens by the lower section. This enabled the patient to find his way indoors and about the city. About a month afterwards iridotomy was performed on the left eye with DeWecker's scissors and the right enucleated. Vision in the left eye was the same as before the iridotomy.

Dr. Coleman also showed a patient from whose left eye he had scooped out the whole contents of the sclera. It was a case of total staphyloma of the cornea from an injury. The operation consisted of abscision of the cornea by two curved incisions, which extended $\frac{1}{4}$ inch on each side into the sclera. The whole contents of the sclera were removed by lid elevator and forceps, and the aperture closed with one suture. The advantages of scooping out the sclera over enucleation, seem to be, a larger and more movable stump, less falling in of the lids, less danger of meningitis as the optic nerve is not injured, or the subvaginal space of the optic sheath opened. The operation he had not at the time seen advised, but since noticed that Dr. Williams, of Boston, recommends it in ophthalmitis.

MICHIGAN STATE BOARD OF HEALTH.

(Reported for the Canada Lancet).

The regular quarterly meeting of the Michigan State Board of Health was held in Lansing, Jan. 8th, 1884.

The secretary read a resumé of the work of this Board during the last quarter, which showed that successful sanitary conventions had been held at Ionia and Detroit (American Public Health Association); that a leaflet on contagious diseases had been translated into French, Danish, Norwegian and Swedish, for distribution among those who speak those languages; that a very general distribution of blanks and circulars on communicable diseases had been made to the health officers and clerks of cities, villages and townships in Michigan; that notice had been sent to health authorities in several parts of the State, warning of the shipment of diseased cattle into such localities; that the regular distribution of weekly bulletins of

sickness and of meteorology, the yearly distribution of material for meteorological reports, and the quarterly distribution of blanks to observers of diseases, had been made.

Dr. Hazlewood attended the Sanitary Convention at London, Ontario, and gave a report of the water supply of that city (London), and the Secretary, who also attended the convention, described a visit to the Asylum for the Insane near London, Ontario.

Committees were appointed to examine and report on the sanitary condition of the jails, asylums, schools, and the capital buildings in Michigan.

Dr. Kellogg presented and read portions of a very interesting report on the present knowledge respecting diphtheria, which will be published in the next annual report.

Considerable discussion occurred over the examination of text books on physiology and hygiene, with reference to alcohol and other narcotics. Only four books had been presented for examination. The committee reported relative to these books; it was directed to confer with a similar committee from the State Board of Education, and to report again at the next regular meeting. It is hoped that publishers of school books will give early attention to this subject, and that more than one book can be approved at that time.

Selected Articles.

SPINAL CURVATURE.

CLINIC BY GEO. HALLEY M.D. KANSAS CITY MEDICAL COLLEGE.

Gentlemen: Spinal curvature—I use that term in preference to spondylitis—may be divided into two great classes,—

1st. That due to organic disease, inflammatory softening of the intervertebral substances, and vertebrae.

2nd. Weakening, or paralysis of one of the lateral sets of muscles of the back.

In the first variety you will find the curvature lateral, angular, or a combination of both lateral and angular, with more or less actual shortening and ankylosis. There is a great deal of pain, and at times, particularly in the later stages of the disease, a great deal of pain from pressure, either on the intercostal nerves or on the spinal cord itself,

manifesting itself in the track of distribution of the filaments pressed on, or in the whole of the cord below the point of pressure. This softening of the intervertebral substances, or bodies of the vertebræ, is always the result of an inflammatory process of a low type, and is manifested generally by a more or less well marked rise of temperature and general subacute inflammatory symptoms.

The patient before you gives us no such history. Has had no pain in intercostal spaces nor in lower limbs. The curvature, as you see, is purely lateral. When I put my hands under the axillæ and lift up with some force, the curvature almost entirely disappears. This patient gives us no history of inflammatory softening; and there being no ankylosis and no angular curvature, we may eliminate organic changes, and, therefore, disease due to the first causes. But the patient does give us a history of chronic hydrocephalus. The head is still enormously enlarged, wearing as he does a seven-and-one-eighth hat. For a time the patient was partially paralyzed, and even now has not the same use of his left hand that he has of his right.

The patient also states that at seven years of age his head was just as large as at present. On closely examining the back I find the maximum of the curve in the dorsal region, opposite the eighth dorsal vertebra, while the compensatory curve is opposite the first lumbar. I also find by examination that the muscles of the left side, attaching the arm to the spinous processes of the vertebræ, are atrophied. He also gives us a history of partial paralysis of this left side, and states that even now there is marked inability to move the limbs on that side with the same degree of celerity that he can those on the right.

Hence, from the lack of organic diseased changes in the bones of the vertebræ or intervertebral substances, with the presence of atrophied muscles on the left side, we conclude that this is a case due to paralysis of the muscles, resulting in deformity from lack of tone on the left side. Now I do not say that weakened or paralyzed muscles may not at times—may perhaps very often—be a most important factor in the production of spinal curvature, in which the bodies of the vertebræ and intervertebral substances undergo organic change. But in this case, and perhaps in a considerable proportion of the slighter varieties of this deformity, we find the muscles, the principal, if not the sole agents in producing and keeping up this deformity, and no organic change, in the way of absorption, and perhaps ankylosis, result.

A few days ago I was consulted in regard to a case where there was very decided lateral curvature, that had existed from childhood, and was evidently the result of an infantile paralysis, with which she was afflicted when quite a child. It was apparently getting worse since she had been confined to a school-room, and taxed with severe studies; hence

the consultation, Now what will you do in such cases? What are the indications? If you follow the routine practice, you will proceed to adjust the regulation Plaster-of-Paris jacket. Now why will you *not* put it on in some others? for it is, without doubt, a most excellent method of treating a certain class of these affections. If you will for a few moments look at the etiology of this case, you will have no difficulty in answering the question intelligently. This case has no diseased bone to repair, no absorbed intervertebral substance to be restored, no inflammatory process to arrest by stopping the irritating cause. In another class of cases this practice would be highly proper, but what would we get here? Only pressure on the already paralyzed or greatly weakened muscles; whereas, what they do require is rest and restoration, by friction, *massage*, and well regulated exercise. I know of no exercise so good in this deformity as that on the horizontal turning-bar. Not for too long a time at first, not to the extent of tiring—wearing out what little strength your patient has; but enough to fully empty the vessels of the blood that is sluggishly circulating in them, as well as the lymph channels. Then let them rest in the recumbent position. Shampooing the muscles with a warm dry flannel cloth will also promote the circulation, and at the same time give tone to the muscular system.

Now if we had put on a plaster-of-Paris jacket, what would we have done? How much good would we have accomplished? We would have straightened the spinal curvature without a doubt, and kept it straight, too, while our dressing was on. But is that all we wish to accomplish in these cases? If the human body was a piece of mechanism which could be propped up at one side or pulled over on the other as occasion required, the plaster jacket would have been just the thing. But it is something more. It is a piece of organism, intended to get along without props or stays; and if you properly follow nature's methods in dealing with this frame, you will find she will generally lead you right. Your jacket, while it held the skeleton in its proper place, would not only have done nothing towards restoring the muscular disorder, but would really have made it worse, by depriving the muscles of their exercise, and impairing their nutrition by pressure, while they were really the parts that required treatment, nourishing and resting.

Now in this case we shall order more outdoor exercise, plenty of good, rich food, and last, but not least, *rest* on a good hair mattress; with *massage* of those muscles that are paralyzed or partially so. I don't pretend to know why cod liver oil does so much good in this class of cases; but I know it does. You will frequently be told, on making such a suggestion, that it is impossible for them to take it; that it always disorders their

stomach; that they can't bear the taste of that "horrid stuff." I tell you, gentlemen, after a good many years of experience, that cod-liver oil can *always* be tolerated, provided you do your whole duty as a physician. First then, see that you have a good, pure, and sweet oil, and that it *is* cod-liver oil; for it is not always cod-liver oil that is sold as such. Nor is all that *is* cod-liver oil fit to put in your patient's stomach. Now if your patient can take it straight, with a table-spoonful of whiskey after it—all right. If the stomach revolts at it or rejects it, you may have to make an emulsion of it with Pancreatin, or a pancreatic emulsion, reducing it with the oil till it is of sufficient consistence, and then add some syrup—syrup of hypophosphites if you prefer—and you have a mixture that almost any stomach will tolerate. If you feel fearful that you may make your patient a drunkard by administering liquor in this way, let me assure you that in all my experience I have never known of such a case. I do not know why, but I suppose the oil prevents the deleterious action of the alcohol on the tissues.

Did this case present evidence of organic changes going on in the spinal column, I should at once proceed to adjust some suitable external means of support—the plaster jacket, the felt jacket, or some other means of allowing the bones and cartilages to resume their normal condition, if that were still possible; and if they had undergone such structural change as to preclude the hope of restoration, to at least secure ankylosis in the best possible position.—*Kas. City Med. Record.*

THE TREATMENT OF GUNSHOT WOUNDS.

We give herewith the following extract from a lecture delivered in Bellevue Hospital by Sir William MacCormack, of St. Thomas's Hospital, London. Speaking of the Franco-German war—he said, we had certainly a large number of operations to perform immediately, in the line of amputations and dressing fractures and wounds of all kinds, but we left all resections until a later date. Such a vast and varied experience is rarely given to any one in so brief a time, and, of course, we availed ourselves of the opportunity as well as we could. We, however, had numerous difficulties to contend with, for we were treating French soldiers who were demoralized by defeat, and, on account of the vast number of patients, they suffered for a time from inadequate nourishment and from an insufficient supply of appliances necessary for all. It was only for a short time, however, that we were thus embarrassed, for soon large extra supplies were forwarded to us. Yet at that time we did not have the advantages of the antiseptic methods of treatment which have since effected such favorable

results, and it was quite distressing to see, in spite of all our care, our patients, with wounds and compound fractures, die of blood-poisoning or erysipelas, which spread from one to another.

I said that we left our resections for a later day. I agree with Von Langenbeck that we should be very careful how we perform resections as primary operations under such circumstances. Primary resections are not satisfactory, or favorable to life, and I think they are infinitely risky. These late resections then performed were many of them on soldiers who were soon after sent away, and they could not be all followed up, but very satisfactory results were sometimes obtained. There are many reasons why such operations as resections should be performed late, after the primary inflammation has subsided, for, after that time, those cases in which amputation should be performed have been selected out, and, besides, the numerous small pieces of bone which are always found in comminuted fractures about the joints have become separated and have disappeared in the discharges, so that the amount of bone that can be saved may then be determined more accurately. A fracture made by a gunshot wound is almost always a comminuted fracture, and later on you can always ascertain the limitations of the diseased process more accurately than at first. We can however, here perform partial operations immediately, and I think that recent experience has clearly shown that these partial operations are not only less dangerous than primary resections, but that they are often followed by more satisfactory final results. Later on, the periosteum about the fractured bones becomes thickened and tough, and rapidly produces new bony tissue, while in the early period the periosteum over a newly fractured adult bone is especially thin and easily torn, besides which it possesses very little osteogenetic power. For these reasons I think that resections are more wisely performed at a late period. * * *

I think, then, that I have shown you, in the first place, that operations of this kind—namely, resections—had better be performed in the secondary period, that they had better be partial if possible and that certain joints, viz., wrist, ankle, elbow and shoulder joint, are more fitted for operations of this character than others.

Now, another thing which I think I have learned and desire to teach you, is to avoid probing gunshot wounds altogether, or as far as possible. I have seen great harm come from this practice, and the fact cannot be too strongly impressed upon you that the bullet itself is of very little importance in these cases. I know that nearly always the first thing that a patient who has been wounded will ask the surgeon is, "Where is the bullet lodged?" and then he will expect to be relieved by its removal. I think that under these circumstances the surgeon is too often apt to be so inconsiderate as to try

please the patient and accede to his wish. Any one who has had much experience with gunshot wounds knows how easy it is to fail in finding the ball, and how difficult it often is to distinguish by the probe between a piece of lead and an exposed surface of bone, or a piece of fascia or a tendon; and in such cases, if he does not succeed in finding the bullet with the probe, he is very apt to search for it with his finger; then he tries with one forceps and then another to extract it, and in this way septic matter is almost necessarily introduced, so that a wound of a joint which might otherwise have healed perfectly without a particle of suppuration is doomed to suppurate, and possibly the whole limb will in consequence be lost. Besides, experience shows constantly how frequently bullets become lodged in muscles, bones, or some of the viscera, and there become encapsulated and never cause further trouble. The point I wish to insist upon is, that there is infinitely more danger created by the surgeon who attempts to search for and extract a bullet than would result from leaving half-a-dozen bullets to take care of themselves. In all the pathological museums throughout the world may be seen specimens of bullets lodged in lungs, liver, brain, and bones, where they had remained imbedded for years without impairing the functions of these organs. At the museum in Washington I recently saw a specimen from a man who had received a gunshot which had fractured the upper part of the tibia, and the bullet appeared to have lodged just below the cartilaginous surface of the lower end of the femur. The surgeon who had attended him at the time of the injury had thought that there was not a wound of the joint, and so had not operated, but had left it alone. The man lived ten years afterward, and after his death this specimen of the bones was brought to the museum at Washington; it was found then that the bullet had caused no injury to the joint at all, and it had not troubled the man for years. I wish by this recital to impress upon you the point that bullets left to themselves are not such dangerous things as they are generally supposed to be. In the recent Turkish and Russian war there was also a strong practical illustration of the value of this let-alone policy. A very distinguished surgeon and a noted professor, both in Berlin and in St. Petersburg, introduced into the hospital the plan of treating all wounds antiseptically, and he had to deal with a great many penetrating wounds of the knee. These he treated by not searching in the tract of the wound with instruments, but he immediately put them up in antiseptic dressings and kept the limb immovable. I quote from memory when I say that nineteen out of twenty-one recovered, not with stiff joints at all, but with movable joints. If you can trust to the evidence of such a series of cases as that, coupled with what I have heard Von Langenbeck say—that he did not believe that a single case of a wound of

the knee joint in the whole Franco-German war recovered—you can see clearly what striking advances have been made recently in the treatment of gunshot wounds. Another thing told me by a surgeon of distinction who has had much experience in several wars in the past few years, was that he never interfered with or probed a gunshot wound of the knee, and his published reports show that the results of these fractures in his hands have been infinitely better than those of any other surgeon. This is another illustration of the importance of avoiding all interference with gunshot wounds. Professor Esmarch, of Kiel, whose reputation you all know, preaches from the text, "don't injure" or "don't do damage," and refers to the interference with gunshot wounds; and I think that I have now said something to show you the importance of such a maxim.—*Gaillard's Journal*.

REMARKABLE CASE IN OBSTETRICS.

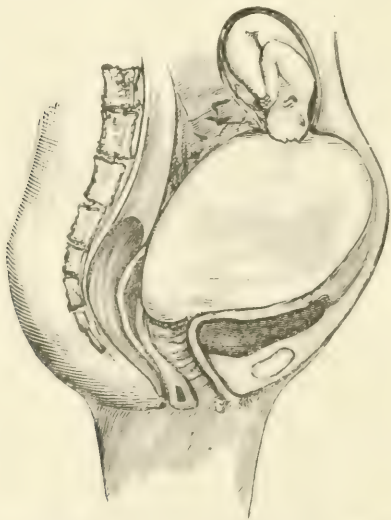
The following remarkable case of obstetrics is reported by T. A. Rodger, in the November issue of the *Canada Medical Record* :—

The patient, aged 32 years, was pregnant for the fourth time. I was present at the birth of all the former children, and found nothing unusual. The history of the case, which is brief, is as follows :—On the morning of the 10th of October I was requested to visit a Mrs. L., whom it was said had been ill all night with great difficulty of breathing. I found the patient in bed, half sitting, half reclining on her side, and propped up with pillows. Her countenance was somewhat anxious, face slightly livid, eyes staring, breathing very hurried and short, and complaining of great tightness about the chest and abdomen, with a sense of suffocation. This being my first visit to this patient at this time, and not thinking that she was pregnant, I at once examined her chest; found heart and lungs normal, but was struck with the size of the abdomen. Her feet and legs were somewhat oedematous, but no great amount of swelling at the vulva. There had been slight pains at long intervals all night, but the patient said "not like labor pains," though she thought that she ought to have been confined some time during the month of September, having, as far as she could recollect, menstruated for the last time about the beginning of the year.

The size of the abdomen being so much out of proportion to anything I had ever witnessed before, I began questioning as to her condition for some time back. She told me that nothing out of the way was noticeable in the size of her abdomen until between the sixth and seventh month; that never at any time could she say that she felt any distinct movement of the child, such as experienced with her other children; that she had suffered considerably at different times from irri-

tability of the stomach, in fact, had often great difficulty in retaining food. A vaginal examination revealed the os to be high up, dilated about an inch, edges tense but thin, membranes entire, but no presentation could now be felt. Examination of the abdomen gave dulness on percussion throughout; no movement or outline of the fœtus could be made out, and by auscultation could not get either heart sounds or placental bruit. Through the assistance of the friends present I changed the position of the patient to one which I thought more favorable, or which might assist me in detecting a presentation, but all without any effect whatever.

The distress of the patient being so great I felt that some measures would require to be adopted at once for relief, so I gently dilated the os until I succeeded in passing the greater portion of my four fingers within the uterus, taking care at this point not to tear the membranes, still no fœtus could be felt. Satisfying myself as to the tough-



ness of the membrane, I passed my whole hand between the latter and the walls of the uterus and endeavored to rupture the membranes with my fingers, but failed. Without withdrawing my hand, I passed, with the left, a knitting-needle, when the rush of water was tremendous.

Continuing my search for the child, my arm acting as a plug in the vagina, I could find nothing in the uterus proper, having passed my hand all around the walls; but, at the fundus, I felt a circular opening about the size of a silver dollar, edges somewhat thick, and unyielding to ordinary force by the fingers. Passed my forefinger through the new opening, touched the mouth, nose and eyes of the child; then gradually succeeded in getting in a second finger when no forehead could be felt, in fact, no head.

With the gradual escape of some portion of the

amniotic fluid I found that I could use more force with my fingers in dilating, due to this second uterus, if I may so call it, being brought near to my hand. Owing to the alarming condition of the patient at this point, and fearing delay might not serve any good purpose, especially if the escape of the amniotic fluid was permitted, there being possibility of collapse, I determined at once upon version and set to work to force my hand into the interior. After considerable resistance had been overcome, both feet of the fœtus were grasped, completing the delivery of a still-born acephalic male child, weighing about six pounds. Fluid extract of ergot was given to ensure uterine contraction, and after delay of a short time the placenta came away by gentle traction with the hand, followed by slight hæmorrhage. The woman was not in a condition to warrant further interference, otherwise I should have liked to have passed my hand and further investigated the interior of the uterus, but feared that possibly such procedure might be attended with bad results.

This is now the 16th day since the patient was confined, and I may state that she is doing well, no bad symptoms having appeared, so far, in the case.

HINTS TO MEDICAL EXAMINERS FOR LIFE ASSURANCE.

We have great pleasure in drawing attention to the following very useful suggestions for the guidance of medical examiners of lives for assurance societies. They seem to us to go straight to the root of the matter, and to enforce the consideration of points not usually engaging attention. They are hints thrown out by no less an authority than Mr. Smee, medical adviser and director of the Gresham Society:—

“A great deal of trouble and annoyance is caused by the sending up of proposal forms imperfectly filled. Sometimes they do not state clearly the occupation or the cause of death of near relatives. Now, it is impossible for the medical officers of society to assess a life if they do not know the cause of relatives' death. With regard to the question of intemperance, too, the agents should see that the paper is strictly and clearly filled up also in the agents' reports which are sent up, and which are confidential, they should state clearly the object of the assurer, and especially in the case of female lives. Persons who have suffered from epilepsy, paralysis, apoplexy, cancer, stricture, stone, must not be medically examined without orders from the head office. No person who has had delirium tremens, who has been intemperate, nor even the reformed drunkard, would the Society accept on any terms. Proposals from persons who are ruptured, who have suffered from gout, rhe-

matic fever, bronchitis, slight asthma, pleurisy, congestion or inflammation of the lungs, varicose veins, eczema or other skin disease, or congenital defect or deformity, or from persons engaged in the occupation of licensed victuallers or in the wine and spirit trade, can only be accepted if strictly healthy, under an endowment assurance tariff, or with an extra rate of premium. To the clerk, master mariner, and the classes who depend upon their exertions for a livelihood, I know of no form of investment equal to an endowment policy; it provides in case of premature death a provision for the family. At the age of sixty a man gets enfeebled in health, and his power of earning is diminished, his premiums cease, and in lieu he receives a lump sum as the result of his savings. Proposals on the lives of persons whose parents have died under sixty years of age must be regarded, even if healthy, as lives not of the first-class; for example, there is one of our noble families in which during the present century no member has reached the age of sixty-five, which must be regarded therefore as what is technically termed the perishing point of that particular family."

No words of ours are needed to strengthen the force of these remarks and suggestions.—*LANCET*.

COMPOUND ARTICULAR FRACTURE.— STIMSON.

In a paper read before the New York Surgical Society, and reported in the *Annals of Anatomy and Surgery*, Nov. 1883, Dr. Lewis Stimson reported three cases of fracture, with the object of drawing attention not to those extensive injuries, in which the question lies between excision and amputation, but to those lesser ones, in which, the injury to the bone and soft parts being comparatively slight, the main feature is the implication of the joint, and the therapeutical problem is how best to avoid dangerous suppuration within it. The first case is one of simple dislocation backward at the right elbow of both bones of the forearm, in a man aged 28. The dislocation having been easily reduced after the administration of ether, a movable hard body, about half an inch in length, was found lying under the skin on the outer side of the joint between the head of the radius and the olecranon, which was judged to be the inner portion of the head of the radius broken off when the bone had been forced backward past the condyle. Believing that this fragment, if left in place, or even if it could be restored to its proper place, would interfere very seriously with the subsequent mobility of the joint, Dr. Stimson at once made an incision and removed it. The joint was washed out with a 1 to 40 solution of carbolic acid, a short drainage tube was inserted, and a gauze dressing applied. The patient did well until

the ninth day, when the temperature rose to 103°, and the joint became painful. Two days later, there was a discharge of pus from the wound. During the next four weeks, there was suppuration around the joint and burrowing of pus. The case ended satisfactorily. The joint remained very stiff for some time, but ultimately the man resumed work as a driver; and when he was seen again twelve months after the date of his accident, the arm was found to be strong and serviceable. Flexion and extension at the elbow were almost complete, but rotation of the arm was entirely lost. The subject of the second case, a man 22 years old, was treated for compound fracture of the left patella. The bone was broken transversely a little below its centre, without comminution, and the fracture communicated freely with a clean-cut transverse wound one inch and a quarter in length, lying directly over it. On the second day Dr. Stimson enlarged the wound, washed out the knee-joint with a 1 to 20 solution of carbolic acid, passed a drainage tube into the joint on each side through an opening made at about the centre of each lateral aspect, brought the fragments of bone together with a silver wire suture, the loop of which included all the soft parts except the skin in front, closed the wound with sutures, and applied a gauze dressing. Much suppuration followed in this case; and the fragments of the patella, it is stated, became united by a fibrous band about one-fourth of an inch long. The movements of the joint were much restricted, but at the time of his discharge, about nine weeks from the date of injury, the patient was able to walk without a crutch, and could flex the knee to an extent of ten degrees without feeling pain. In the third case the patient, a man 47 years old, came under the care of Dr. Stimson with a compound fracture of the left ankle. The left fibula was broken at a point about three inches above the top of its malleolus; the inner malleolus was broken off at its base, and this fracture communicated with a transverse wound of the skin directly over it, through which blood flowed freely. A small piece of bone which lay in the wound was removed. The surface of the limb at the seat of injury was washed with the carbolic acid solution, but the wound was not injected. Gauze dressings were applied with lateral splints. On the third day a plaster-of-Paris splint was applied. The patient, who presented at first some symptoms of alcoholism, ultimately did well; and after an interval of two months and a half, the joint was freely movable and painless.

In his comments on these cases Dr. Stimson concludes with the following statement. "Of these three cases, the one that did best was the one that was least interfered with (it was also that in which the injury was least, but the difference in this respect was not great enough, I think, to account for the difference in the results); and I find in this

fact, and in the fundamental success obtained in all, ground for the belief that confidence in modern methods of treating wounds should incline the surgeon rather towards absolute conservatism than towards operative interference; that in cleanliness, drainage and rest, we have agents efficient in themselves to avert inflammation of the joint, or, failing that, to keep the inflammation within such limits that the risks of an operation, if it should become necessary, are not materially increased; that the safeguards now possessed against the occurrence of formidable complications of wounds should give confidence to expect the comfortable healing of wounds accidentally inflicted, rather than stimulate to the voluntary creation of new ones; and that the broad rules of treatment such as those under consideration should be to avoid excision except when it is clearly indicated by the extent of the injury, the difficulty of establishing drainage, or by an economical reason arising from the function of the joint involved and the social condition of the patient that may make mobility, even if combined with some insecurity, preferable to ankylosis."—*Lon. Med. Record.*

TREATMENT OF EPILEPSY.—CLINIC BY PROF. PEPPER.

Gentlemen,—I shall to-day call your attention to two men, who are suffering from epilepsy.

This young man, a native of England, was healthy up to the age of four years, when he suddenly lost consciousness and fell over, while sitting at the table. One year afterward, the convulsion returned, and from this time he has been the prey of epileptic seizures, occurring at varying intervals. This is a bad case. It has been noted that he has had as many as one hundred and twenty convulsions in twenty-four hours. He states that when fourteen years old he fell into a trance, lasting for two or three days. After this he enjoyed freedom from the epileptic attacks for two or three years. About five years ago hemiplegia of the left side came on. This has gradually improved, but the arm and leg are still paralyzed to a certain extent. In walking, he drags his leg in a clumsy way, after the fashion of an old hemiplegic. The muscles of the shoulder and arm still retain some power, but the flexor and extensor muscles of the hand are almost completely paralyzed.

The attacks are somewhat controlled by bromide of potassium and hydrobromic acid. He thinks that he has been improved by treatment. His memory has become much weakened, and all his statements must be taken with a certain degree of allowance. There is no evidence of fracture of the skull and no history of his having received such an injury. The attacks are of the character of ordinary epileptic fits.

This second man is a machinist. He never had a fit until he was thirty-three years old. It came on suddenly, while he was at work. This man's memory appears to be good, so that we can depend on his statements. The attacks occurred at first at intervals of two or three weeks. Under treatment they became less frequent, but when treatment was stopped they increased in frequency. He has gone as long as four months without an attack, but they have never been entirely arrested. Immediately after the attack he passed into a state of mania, lasting from fifteen to thirty minutes.

Among the predisposing causes, inheritance is a powerful one. When a child comes of a family of strongly marked nervous temperament, if several members of the family have exhibited symptoms of nervous disturbance, and if the child began at an early age to show a tendency to irregular nervous manifestations, the probability is that there is such a profound morbid tendency of the nervous system, that no effort will control or eradicate it. Another predisposing cause is long continued exhausting illness. This may excite a tendency to convulsions at any age. A short time ago, a lady consulted me, and gave the following history: she had been perfectly well up to five years ago, when she had a very severe attack of typhoid fever. This was complicated with hemorrhages, phlegmasia alba dolens of both legs, and relapses of fever, keeping her in bed for four months. After this passed away, and after she began to go about, she had a convulsion following some unusual exertion. For three years convulsions of an epileptic character continued, recurring at varying intervals, sometimes as frequently as twice a week, and at times being so severe as to require the strength of two persons to restrain her. Gradually, as her health improved, the attacks became less severe and less frequent. For the last six or eight months she has had no general convulsion, but has had periods of momentary oblivion, attended with severe pain in the region of the heart. She is evidently outgrowing the convulsive tendency, which was called into activity by the violent attack of typhoid fever. Last week I saw in consultation a case of the same character—a case of typhoid fever with severe hemorrhages leaving the patient in a state of the greatest debility. After the fever had subsided, the patient had a severe convulsive attack. Unless great care is taken I have no doubt the convulsive tendency will show itself in that patient just as it did in the woman to whom I have referred. Where there has been no inherited tendency, and where the child has not shown a disposition to convulsions, the attacks after protracted disease are not of so unfavourable omen, as where they come on in consequence of constitutional tendency.

I need not say to you that accidents in childhood often produce this tendency. It is exceedingly difficult to make the prognosis in such cases.

Children so frequently meet with accidents, that it is exceeding difficult to say whether the convulsions have resulted from a blow, or whether the child has an inherited tendency which is just showing itself. Still you will be pressed for an opinion by the parents. If there is any actual injury, such as a depressed fracture, or if the accident were followed by unconsciousness or paralysis, or mental affection, showing that the cortex of the brain had been involved, you will have no hesitation in expressing the opinion that some injury has been done, and according to the seriousness of the injury and its curable character, will be the prognosis. More frequently, however, you will be forced to conclude that the shock to the nervous system has excited the convulsions. If the injury has been slight, the prognosis is bad, but if the injury has been severe the prognosis is more favorable. If there is evidence of permanent injury to the brain, the prognosis is of course unfavorable. In the case of this boy, I cannot say whether or not he has had a hurt, but we have in the hemiplegia evidence of serious intra-cranial disease. There has been in all probability, a lesion either in the corpus striatum or in the cortical centres corresponding to the muscles of the left side, which has left behind it a loss of substance and a cicatricial condition of the brain itself which is incurable. I should, therefore, in this case, have no hope of eradicating the tendency to convulsions. It will be kept up perpetually by the organic lesion of the brain which exists.

A short time ago I showed the results of a post mortem in the case of a physician who many years ago was thrown from his buggy, his head striking against a tree, causing a depressed fracture of the internal table of the frontal bone over the right eye. He immediately had coma, which lasted two or three days. He recovered, and was apparently perfectly well from 1860, when the accident occurred, until 1881. He served in the army during 1881, and reached the rank of full surgeon. After leaving the army, he settled in a southern town, built up a good practice, and laid by some money. He then moved North, buying a good practice in one of the towns of Pennsylvania. In 1881 he began having convulsions of intense severity, recurring at long intervals. When the case came under my observation, some eighteen months ago, it gave rise to some embarrassing questions. Had there been an injury to the bone so long as twenty years previously, which had remained dormant, and was there now developing some slow lesion near the seat of injury, the result of this hurt; or had the shock to the nervous system, causing the coma and unconsciousness, left no serious lesion, but now, in consequence of overwork and depressing influences, had there been a revival of this tendency without actual disease, and should we trephine this man or not? For a time

we decided not to trephine, but the convulsions continuing, we did trephine, but it did no good; the convulsions continued, and the man died. The autopsy revealed an abscess in the anterior lobe of the right hemisphere, with a secondary abscess in the anterior lobe of the left side. There can be little doubt that a slow, irritative lesion had existed during all these years, and the brain had become habituated to its presence; and it was not until a large area of the brain became involved, that the system responded to its influence and convulsions made their appearance.

In children with convulsions, where there is a history of an injury with perhaps some lesion of the head, you will often find it difficult to decide whether or not any operative interference should be adopted. Usually you will find that you cannot decide upon having the head trephined. Yet I am satisfied that we ought to trephine the head for epilepsy more frequently than we do. Wherever there is a lesion of the cranial walls, although there may be no depressed fracture, where there is possibly some lesion of the membranes, and where the convulsions cannot be controlled, my judgment would be strongly in favor of trephining. I have seen some most excellent results follow this treatment. The lives of these patients are so sad and so sadden the lives of those around them, that although we may to a certain extent control the attacks, yet this is not very satisfactory, and therefore the chance of obtaining a radical cure is worth a good deal of risk.

Another and extremely difficult question comes up in the treatment of young children, such as this lad was fifteen years ago, and that is the question of intellectual development and training. A child of five or six is attacked with epilepsy. Such children are often among the brightest and most intelligent, and frequently are even precocious in their intellectual development. Yet it is clear that if the brain becomes excited by study, too much reading, or violent play, the convulsions will become more severe and frequent. In presenting this question to parents, they have argued that it was better to allow the child to continue at school for if allowed to grow up ignorant, and without mental training, he would, if shut out from the world by reason of his disease, be unable to occupy his mind, and might readily fall into vicious habits; and if the attacks should be relieved he would, in consequence of his want of education, be unable to take his place in life. Therefore they have argued that it was better to take the chances of keeping up the disease than to allow the child to grow up in ignorance. To decide how far we should interfere with intellectual work, and how far the advantages of such interference counterbalances its disadvantages, is one of the most difficult to solve. My own judgment is decidedly against allowing these children to study or go to

school. If taught, they should be taught at home, and emulation, ambition, and excitement of every kind should be studiously avoided. They should be taught, as far as it is proper to teach them, at home and not in schools. Specious as are the arguments pressed upon you by the parents against this plan, the results of yielding are usually bad. Epilepsy, even when taken at the earliest period, is not a disease which in my experience has been cured by drugs alone. It has been by the regulation of diet, regimen, and hygiene, and secondarily by drugs. But allowing the child to go to school, and when the convulsions become more frequent, increasing the dose of bromide of potassium, and when that loses its effect, changing to bromide of calcium, bromide of lithium, or hydrobromic acid, can have only one ending—and that is the enfeeblement of the whole nature of the patient, mental, moral, and physical, and the settling upon him of a hopeless bromide habit, without eradicating the epilepsy. There are some few cases in which a radical cure can be effected by drugs. There is a larger number of cases where with proper hygiene and the continued use of suitable remedies, the disease can be kept in check indefinitely. There is a still larger number of cases, and this may be said of almost all cases, in which if you depend upon drugs alone, and do not pay the first and closest attention to the regulation of every point of the daily life, you will find that the case goes from bad to worse, and that the effect of the drugs has been bad, without influencing the disease. There is an enormous amount of damage done by the way in which bromides are used in convulsive affections.

I should regulate the life of such a child in the following way:—Go to bed at seven o'clock and lie in bed till eleven o'clock in the morning; take a walk, come in and study, dine; after dinner, play, or walk again, then rest, and retire at the hour mentioned. Sometimes this can be carried out; at other times the child is so restless that any attempt to enforce such rules will do more harm than good. Where the child can be restrained, I regard prolonged rest in bed as one of the most useful adjuncts to the treatment of juvenile epilepsy. I have seen remarkable results follow this line of treatment. I recall a case in which I suppose a cure has been effected, for it has been a year since the child has had a convulsion. The patient was a boy, born of nervous parents, a boy of brilliant intellect, and ambitious in every way. He had convulsions while teething, and at the beginning of an attack of scarlet fever, when three years of age. He had grown well and appeared perfectly healthy up to the age of eight, when the epileptic attacks made their appearance. They proved obstinate and violent. He was removed from school and sent to a farm, allowed to play out-of-doors, and took bromides in moderation. The convulsions

soon stopped, and for six or seven months he was free from them. He was regarded as cured, came home, went to school, and the same thing happened again. The fits proved intractable. They became severe, and recurred with increasing frequency. He was again sent to the country, but this did no good. I decided to adopt more radical measures. I persuaded him to go to bed, and kept him in bed for three months constantly. During this time he took regular doses of the bromides, and his diet was regulated with extreme care. The convulsions occurred less and less frequently, and finally stopped entirely, and he had none for several weeks. He was then allowed to get up for an hour each day. The length of time out of bed was gradually increased until he returned to his ordinary mode of life. He has not yet been allowed to return to school. I have seen this same result in many other cases.—*Med. and Surg. Reporter.*

NEW METHOD OF TREATING DEEP-SEATED TUMORS.

There are certain varieties of tumors which frequently make their appearance in the neck, and bear such a relation to the deep blood-vessels that removal by extirpation is too hazardous to be undertaken—tumors which are benign in character, yet endanger the health of persons afflicted with them by the pressure which they make upon surrounding parts. Some of the tumors found in the parotid region are of this benign character but become dangerous to health through the pressure they exert upon the nerves of the region, and through the interference, which they cause with the free movement of the lower jaw. All of the tumors of deep origin in the neck are difficult of removal, and attempts at this procedure are often followed by fatal hæmorrhage or equally fatal phlebitis. Any method of treatment which avoids these unhappy contingencies and promises arrest of growth or complete destruction of the tumors, will be the accomplishment of a great desideratum. In this connection I desire to relate the case of Mrs. L., who consulted me for the cure of a tumor of the parotid region, which first appeared as a small lump beneath, and a little anterior to the ear, some fifteen years ago. She is 37 years of age, of previous good health, sound family history and mother of several healthy children, the youngest three months old. The tumor had attained the size of a goose egg, was of irregular contour, not freely movable and appeared to involve the whole parotid gland. The facial nerve had been paralyzed by the unyielding pressure for several months, during which time she had endured unmitigated pain. The jaws could be separated just barely enough to admit the handle of a spoon. The growth had never been especially rapid, but had

increased gradually from the commencement, years ago. Her sufferings were now so intense that she felt they could no longer be endured and consequently she urged to have the tumor removed. With this object in view I put her under the influence of ether and with the assistance of Dr. Chaney and students Babcock and Collar, proceeded to operate as follows: An incision was made just in front of the ear from a point about one inch above the external auditory meatus, and carried downwards in the neck parallel with the anterior margin of the sterno-cleido-mastoid muscles to the external jugular vein. This wound was deepened to thoroughly expose the more superficial part of the tumor. Then with the handle of the scalpel and my fingers, the deeper parts were separated from the surrounding tissues until the base was reached; the external carotid artery was found to pass through the tumor behind the angle of the inferior maxillary bone, at which point there was a considerable constriction of the growth, apparently to accommodate the limited movement of that bone. Stout ligatures were passed about the artery at that point; and also about the constriction. Exploring deeper with fingers and scalpel the base of tumor was found prolonged beneath the base of the skull, and having such a relation to the internal jugular vein that that vessel would require ligation near its origin if further steps at its removal were undertaken. This latter procedure I did not deem it advisable to execute in view of the great danger from excessive hemorrhage or from phlebitis. Accordingly I abandoned the original purpose of the operation and amputated that portion of the tumor which had been isolated by the strong ligature passed about the constriction, introduced a drainage tube into the deep sulcus which I had excavated around the tumor, and brought the external wound together with interrupted sutures. The patient has enjoyed, since the operation, five weeks ago, complete relief from pain, and the tumor has entirely disappeared.

It is apparent that the attempts at isolation of the tumor made in this case must have destroyed all vascular parts passing into the capsule excepting those which enter from the base and are intimately associated with the deep vessels of the neck. Now, the point is that such interference with the vascular supply of these tumours will check their growth and may in some instances occasion their complete destruction. A sufficient supply of blood is maintained through the deep adhesions of the tumor to prevent gangrene and the consequent danger of septicemia, but not enough to maintain the rapid growth which may be expected when these tumors pursue their natural course.

Nussbaum, the experienced Bavarian surgeon, has advocated this method of treatment. It is said that in his hands it has proved a most gratifying success. In the present case the nutrition of the

tumor ceased from the day of operation. The color gradually changed from a pale pink to a dull white; and ten days after the operation, was easily removed from the wound with dressing forceps. As a dressing for the wound to guard against septic infection, a solution of boracic acid $\frac{3}{4}$ j, corrosive sublimate gr. j. in pure water Oij. was doused into it twice daily. There was very little constitutional disturbances following the operation. On the third day the patient resumed the care of her nursing infant and assumed light household duties. Four weeks after the operation she had so far recovered health and strength as to be able to journey by rail to her home, eighty miles from Detroit. The results of operations for the removal of tumors of deep origin in the neck have not been satisfactory in the hands of the average surgeon, nor have his more distinguished colleagues succeeded better, but, I cannot but believe that the method resorted to in the above case admits a wider range of application, and may some day prove useful in the treatment of tumors of the thyroid gland. It is certainly as rational a method for such tumors as is extirpation of the uterine appendages for the cure of uterine myoma. The principle involved is impairment of nutrition by destruction of vascular supply.—*Dr. Wyman, Med. Age.*

ANTISEPTIC SURGERY AT BELLEVUE HOSPITAL.

Whether a surgeon believe in the germ theory or not, is a matter of little practical importance; but certain facts which are pertinent to the subject of germ development must be accepted by all. The discharges from wounds contain nutritious material for bacteria of different forms, and these bacteria rapidly avail themselves of the opportunity to propagate their kind whenever they are not prevented from doing so. The products of the decomposition caused by their growth are irritating to a wound, and change the natural order of reparative processes, to say nothing of the probability that special bacteria provoke particular forms of inflammation.

Any one can see bacteria who will take the trouble to look at them, and any one can appreciate the harmful influence of their presence in a wound if he will compare a wound containing many of them with a wound in which few have been allowed to enter. We are possessed of the means for restraining the development of bacteria, and whoever fails to gain this end fails to avail himself of the proper opportunities for making an aggression against the entrance of bacteria into a wound.

If the surgeon be perfectly familiar with the nature of fermentation processes, it is still no easy matter for him to take the necessary precautions for preventing them, and the most rigid following-out of the technique in his methods is required to

insure success. Success is sure to follow strict antiseptic precautions, but it must be remembered that bacteria will crawl into the spigot if the bung alone be stopped.

Probably no better place than Bellevue Hospital can be found for comparing the benefits of antiseptic measures with the results of ordinary wound treatment, and in the wards where the details for keeping wounds in an aseptic condition have been carefully studied most gratifying results have been obtained. It is a common thing for very bad compound fractures and the largest of operation wounds to heal under one or two dressings, and such dressings remain perfectly sweet for three or four weeks at a time, so that there is no necessity for the surgeon disturbing them in any way. The patient, instead of having his wounds dressed every day or two while profuse suppuration is draining away his strength, quietly reads his paper and peacefully chews his tobacco while the surgeon passes through the ward and glances at the temperature chart at the head of the bed. In the wards in question pyæmia and septicæmia are unheard-of diseases, and foul, purulent wounds are entirely out of date. Primary union is by far the commonest method of repair, and in granulating wounds the discharge is so small in quantity that it seldom appears through the permanent dressings.

Various methods and different kinds of antiseptic dressings are employed in the different divisions, but the commonest antiseptic solutions are of carbolic acid, bichloride of mercury, salicylic and boracic acids. Iodoform is in constant use. Carbolized gauze, borated cotton, or prepared peat, form the larger part of the bulky dressings. Ligatures are carefully prepared before being used, and so are drainage-tubes and protection silk. The solutions of carbolic acid are aqueous ones, and in the proportions of one part to twenty, one part to thirty, or one part to forty of water. Bichloride of mercury is diluted with from one thousand to five thousand parts of water. Salicylic and boracic acids are usually combined in the proportion of one part of the former to six parts of the latter, and these are dissolved in five hundred parts of water. In some of the wards the orderlies and nurses are given written directions, and the following is a copy of these:

"I. No one shall touch a wound, or the vicinity of a wound, unless his hands are thoroughly carbolized.

"II. No material shall be allowed to touch a wound, or the vicinity of a wound, unless it has been antiseptically prepared.

"III. No sponge shall be employed about a wound unless the sponge has been antiseptically prepared.

"IV. No prepared sponge shall be used after it has come in contact with any substance which has not been rendered aseptic.

"V. Sponges are not to be touched by any person whose hands are not carbolized

"VI. Sponges employed are not to be used at more than one operation.

"VII. During an operation sponges that are bloody are to be washed in a solution of carbolic acid (1 to 40), and by a person whose hands are carbolized.

"VIII. Protective silk and rubber drainage-tubes are to be kept in bottles filled with carbolic acid solution (1 to 40), and these articles are to be removed by the senior or junior assistants only.

"IX. All material for dressings is to be kept in a perfectly clean place, and the material shall be handled only by carbolized hands.

"X. Dressings are to be made up by such persons only as have carbolized hands.

"XI. Dressings are to be prepared on clean towels and must not touch surrounding objects.

"XII. Instruments are to be kept in carbolic acid solution during an operation, and are to be handled by aseptic hands only."

In giving a description of the routine which would be followed in an operation, it is perhaps best to select some particular case. Let us suppose, for instance, that a man who has suffered a compound fracture of the patella has just been brought in. The patient having been undressed is placed upon a table, which is covered with a rubber blanket and which slopes downward from the end where his head lies. The blanket is gathered at the lower end of the table so that irrigating fluids may run into a pail placed for their reception. Above the table is suspended a large pail which contains any one of the antiseptic solutions which the surgeon may prefer, and descending from it is a long rubber tube supplied with a sprinkling nozzle and stopcock. The injured knee is now scrubbed with soapsuds and the hairs in the vicinity are shaved off with a sharp scalpel or razor. The knee and the leg above and below are washed with strong carbolic acid solution, and towels which have been wet with the same are placed in every direction about the limb, leaving exposed only that portion which immediately concerns the operator. One assistant is to share the work of the operating surgeon, another handles instruments, and another manages the irrigator. The nurses handle the sponges which are being used by the surgeons, and all parties, with the exception of the one who gives the anæsthetic, have rendered their hands aseptic. The operator now makes an incision which opens up the knee-joint widely and exposes the fragments of the patella. The fluid from the irrigator is thrown in jets over the wound and all clots are washed away. Bleeding vessels are attended to, and the fragments of bone trimmed so that they be readily approximated, and at frequent intervals the irrigator is made to play over the exposed parts. The patella having been firmly

wired with strong silver wire, the soft parts are brought into place and sutured with catgut, each structure being separately sutured. A drainage-tube has been inserted through a counter-opening at the most dependent part of the synovial sac, and everything is ready for the dressings. Iodoform is first sprinkled over the wound, and then strips of protective silk are laid upon the sutured line of incision. Wads of loose carbolized gauze are placed about the knee to allow of free percolation of discharges, and over all a bulky dressing of borated cotton, between layers of carbolized gauze, is bandaged with a carbolized roller bandage. Any splint which the surgeon may prefer is then applied, and the patient placed in bed. If serum appears through the dressings afterward, iodoform is sprinkled over the part and an additional wad of borated cotton bandaged on. Should the surgeon wish to change the dressing an irrigator is employed for sprinkling the knee while this is being done. If absorbable drainage-tubes have been used the dressings will probably not be changed for several weeks; but if the drainage-tubes be of rubber they would be removed at the end of ten days.

A patient treated in the manner described would probably not have at any time a temperature much above normal, and it is a common thing for all of the vital signs to remain normal after the first day or two. In case the temperature should run up to 102° F., a change of dressings and a purge would be indicated.

After the patient has remained quiet long enough for reparative processes to be completed the dressings are removed, and the surgeon has only to begin passive motion for the completion of his restorative measures.—*Med. Record.*

RODENT ULCER AND EPITHELIOMA.—Dr. Hume (*Brit. Med. Jour.*, Jan. 5, '84) says: The only conclusion which seems to be borne out by all the facts, both pathological and clinical, is that rodent ulcer is a form of epithelial cancer which begins in the external root-sheath of the follicles and in the sebaceous glands. It is of the same essential nature, therefore, as epithelioma; but it differs pathologically in the mode of development of its cell-growth, just as it differs clinically in the absence of gland-infection and in its slight general malignancy.

Some explanation of these clinical differences may be found in the character of the cell-growth in the two diseases. In epithelioma, there is a marked tendency to an unrestrained cell-infiltration of surrounding structures, so that infection of the lymphatic system readily occurs. The cell-growth of rodent ulcer, on the other hand, is in the form of isolated masses which, originating in the follicles and sebaceous glands, are, at least for

some time, restrained by the firm fibrous sheaths of these structures. The tendency of these masses is, therefore, to cause, by their pressure on the tissues, a persistent ulceration in which they, as well as the tissues, perish. But because this local destruction takes place rapidly, and because of the absence of cell-wandering, lymphatic infection is not prone to occur.

The suggestion was made some years ago by Mr. Jonathan Hutchinson, that the difference between the two forms of epithelial cancer must be determined in some way by the difference of locality in which they occur. The foregoing account of the genesis of the cell-growth in rodent ulcer, seems to supply the *rationale* of this suggestion. Commencing in the continuity of a skin-surface, rodent ulcer is peculiarly apt to attack that part of the face—the side of the nose—in which the sebaceous glands are strongly developed, and I have endeavored to point out the manner in which the structure, when the disease begins, determines its onward course. As bearing upon this supposed influence of locality, it would be an important point to decide whether an ulcer which began as undoubted rodent ulcer in the upper half of the face may not become changed to the epitheliomatous type, when in its ravages it reaches the region of the mouth. One or two cases which I have seen in a very advanced period of their course, in which the invasion of the region of the mouth appeared to be speedily followed by glandular infection, seemed to lend countenance to this view.

MEDICAL ETHICS—Dr. Gihon, medical director U. S. navy, president of the naval medical society, read a paper on "Medical Education in Relation to Ethics" before the Section in State Medicine of the American Medical Association, at Cleveland, June, 5, 1883, which is published in the journal of the association, with the following note appended: "I deem it proper to reaffirm my loyalty to the code to which I have subscribed, without, however, surrendering the right, which in common with every intelligent man I claim, to criticise what I may think objectionable, and to call attention to the inconsistencies of its avowed adherents, who, attempting to observe its letter, ignore its spirit. I fail to see why honest advocates of its principles should be placed in an attitude of "rebellion" for merely defining these principles by the more liberal light of this day. The code properly interdicts any admission of the orthodoxy of the professors of exclusive dogmas, whether of homœopathy, allopathy, hydropathy, or the like; but it nowhere prohibits the intelligent physician giving *his* advice to whomever may seek it, especially when emergencies and the dictates of humanity demand. No one can more energetically discountenance than myself the impossible co-treatment of any case of disease by an

educated physician and a charlatan, empiric, quack or ignoramus, however regular; but it is quite another matter when one's own opinion is solicited in the interest of suffering humanity. I have yet to hear of any one of our profession soliciting an opinion from any of these, and without such an interchange of views there can scarcely be considered any *consultation*, in the sense of the clinical co-operation properly denounced by the code. Any narrower assumption will, as I have endeavored to shew in this paper, necessitate the ostracism of those of our famous colleagues who have associated as fellow medical members with homœopaths and eclectics in the professional work of the national board of health, state boards of health, boards of medical examiners, etc.; and I feel assured that the overwhelming sentiment of the American Medical Association will be in favor of the liberal interpretation I have here given the code, with the previous knowledge and approval of the surgeon-general of the navy."

PROFESSOR STOKES ON NERVE-STRETCHING.—Following closely upon the report of Mr. Marshall's Bradshawe lecture at the College of Surgeons, on "Nerve-Stretching for the Relief or Cure of Pain," comes an account, from Prof. W. Stokes, of Dublin, of the results obtained in two cases of locomotor ataxia in which the sciatic nerve was stretched. In the former of these the success was sufficiently encouraging. The operation was followed by the restoration of plantar sensibility, by marked diminution both in frequency and intensity of the shooting pains, and by temporary relief from vesical irritability. There was no return, however, of the patellar reflex, no improvement in locomotive power, and no change in the muscular incoordination. The force employed was estimated roughly at about eight or ten pounds. Antiseptics were used, and the wound, though slow in healing, was always aseptic. In the second case both sciatic nerves were stretched, and very marked and abiding were the beneficial effects, although "severe constant pain at the situation of the operation, accompanied by spasmodic contraction of the muscles of the leg, were complained of by the patient for some hours after the operation." The lightning pains were absolutely abolished; there was temporary increase of power in the legs, and the urinary troubles were abated. Prof. Stokes remarks that the *rationale* of the treatment remains as yet unexplained, although he admits a possible solution of the problem based on the observations of Drs. Brown-Séquard and Bastian, that the operation produces "a certain amount of vaso-motor paralysis resulting in vascularity and increased temperature, and that these may lead to improved nutrition of the affected part." Prof. Stokes differs from Mr. Marshall as to the advisability of using a dynamometer to estimate the force exerted, since he has

decided to employ it in future operations. Prof. Stokes' experience leads him to the conclusion that a force of ten pounds is sufficient for the sciatic nerve. Mr. Marshall thinks one of thirty pounds is a very safe one. Both assert eighty-eight pounds, the maximum fixed by M. Artant, to be replete with danger. Reference may be made to Mr. Marshall's lecture in *The Lancet* of Dec. 15th, 1883, and to a leader thereon in the succeeding number.—*Lancet*.

A NEW DRESSING FOR WOUNDS.—From Prof. Bruns, of Tübingen, we receive a fresh addition to our means for carrying out the after-treatment of wounds, in the form of a preparation which he calls "wood-wool," and which he recommends to surgeons (*Berl. Klin. Woch.*, No. 20). Fine-grained wood in the form of splinters and shavings, such as are largely employed in paper factories, according to Bruns, is the kind of material to be used in preparing the dressing which is called wood-wool. Pine wood is preferred, and especially the *Pinus picea*, which is poorer in resin and of coarser grain as compared with the wood of other pines and firs. The further preparation of the wood shavings and splinters consists in their reduction to a state of finer division by being rubbed through a wire sieve, then dried, and finally impregnated with various antiseptic substances. That considered best is a half per cent. of corrosive sublimate and ten per cent. of glycerine (the percentage apparently referring to the ratio between these substances and the wood-wool). The advantages of such a dressing are believed to be manifold. Compared with ashes and turf it is absolutely clean, fresh, and of white color, and is soft and pliable like ordinary wool, and, withal, of extraordinary cheapness. It possesses, in virtue of its contained resin and ethereal oils, certain antiseptic properties, and is so easily adapted to the wounded parts and of such elasticity that a uniform and equable pressure is easily obtained. Its principal property, however, is its extraordinary power of taking up fluids: in this it excels all other forms of dressings; it absorbs twelve times its own weight of fluid, so that ten grammes of dried "wood-wool," after complete saturation, weigh one hundred and thirty grammes. Simple sawdust absorbs only three to four times and a half its weight of water, ashes only nine-tenths, and sand only four-tenths. This dressing has been in use by Bruns for half a year, and he has every reason to be greatly satisfied therewith. With the exception of one case of erysipelas, no secondary accidental wound-diseases were met with.—*Med. Times and Gazette*.

TREATMENT OF SPINAL CARIES BY OPERATION.—A paper by Mr. Frederick Treves on the above subject was read and discussed before the Royal Medical and Chirurgical Society. Mr. Treves con-

tended that the gravity of spinal caries depends not so much upon any special pathological feature in the process as upon the depth at which the disease is situated, and its inaccessibility to the usual operative procedures applied to caries elsewhere. Diseased bone cannot be removed from the vertebral bodies, and the morbid products having to travel a great distance in order to be evacuated, are apt to induce immense purulent collections. These collections are usually opened at a point remote from the original seat of the disease. In the operation proposed by the author the anterior surfaces of the bodies of all the lumbar vertebræ and—with some reservation—of the last dorsal vertebra, can be reached from the loin. A vertical incision is made near the outer edge of the erector spinæ; the sheath of that muscle and the quadratus lumborum are cut through; the psoas muscle is incised and the vertebræ reached by continuing the operation along the deep aspect of that structure. The details of the procedure are fully described. By means of this operation the vertebræ can be readily examined, carious or necrosed bone can be removed, a ready and direct exit can be given to all morbid products; an abscess situated in the psoas muscle or in the lumbar region can be evacuated while it is yet small, and before it has led to a huge abscess cavity. If a large psoas or lumbar abscess exist it can be evacuated at its point of origin, and at a spot that, in the recumbent posture, corresponds to its most dependent part. If Hueter's statement be true, that the two vertebræ most frequently attacked by caries are the last dorsal and first lumbar, the operation should be capable of frequent application. The author details three cases in which he performed this operation. All the patients made a good recovery. In one of the instances he evacuated at its point of origin a psoas abscess containing forty ounces of pus, and removed from the body of the first lumbar vertebra a large sequestrum measuring one inch by half-an-inch. The immediate improvement in this patient's condition was very marked. In another case the psoas abscess had been opened in the thigh some months previously. By this operation a counter opening was made at the point of origin of the abscess from the lumbar spine, and the entire abscess cavity was drained by a tube passing from the origin of the psoas muscle to its insertion. —*Med. Times and Gaz.*

THE COUVEUSE, OR ARTIFICIAL NURSE.—This apparatus was introduced into the Maternité at Paris, by Tarnier, in 1881. It is composed of a wooden box, the walls of which are about four inches thick, and filled in with sawdust. The box rests upon a pedestal. The height of the whole couveuse is thirty-eight inches, length twenty-eight inches, depth thirty-four inches. It is divided into two compartments by a central division. The

lower compartment contains warm water; the upper is for the infant. The metal case holding the warm water almost entirely fills the lower compartment. Between the walls of the box and the metal case is a free space for the circulation of air, which enters from the bottom of the apparatus, and after circulating, escapes through apertures in the top.

The infant is placed in the upper compartment. It is separated from the water-tank by an air-space, and communicates with the exterior by two openings, one for the escape of air, the other for removing the infant when necessary.

A thermo-siphon is attached to the water-tank, which heats the water by a spirit-lamp. The temperature is determined by placing a thermometer by the infant. The water is removed by the stop-cock at the bottom, and introduced through the upper tube leading from the thermo-siphon. The temperature is kept at a mean of 86° F. Dr. Budin has attached an electric alarm, in case the heat becomes too great.

At the Maternité the infant is generally placed under the care of a nurse, as the mother is usually in another ward. When the infant is born before term and is very feeble, it is fed on pure asses' milk from a spoon or glass. The infant is clothed just as other nursing infants. The linen is changed five or six times a day, and a daily bath is given.

SYPHILITIC NEURALGIA.—Prof. Seeligmueller read a paper on this subject at the Fifty-sixth Versammlung Deutscher Naturforscher which recently met in Freiberg.

Neuralgiæ, he said, which are recently related, etiologically, to constitutional syphilis, are nothing like so uncommon as would be supposed on reference to the literature of the subject. He does not refer, of course, to the cases of neuralgia following syphilitic periostitis, or to the osseous pains, but only to such cases in which the pains occur along the tracts of nerves. Such cases have been observed by Fournier in the course of the supraorbital and sciatic nerves. Seeligmueller has also observed them in the course of other nerves, as the intercostals, the brachial plexus, and the great occipital.

Lately he has observed, it seems, a very typical localization of syphilitic neuralgia in the head, and certainly along nerve tracts, which were formerly supposed to be cases of isolated neuralgic affections in unusual places. In these cases the pains were spontaneous, as though pressure had been made along a tract two or three fingers wide, and which extended on both sides from the ear upward to the top of the head. He has further seen cases in which the pains were confined to a limited zone and to the course of sensitive nerves, as the auriculo-temporal and small occipital. There was no middle-ear disease in any of the cases.

The time at which the neuralgic affection comes

on after syphilitic infection varies from two to fifteen years. The treatment is, of course, antisyphilitic.—*Deutsche med. Wochenschr.*, October 24, 1883.—*Med. News.*

THE TREATMENT OF ACUTE BRONCHITIS.—With the view of promoting the free secretion from the bronchial mucous membrane, Dr. Main (*Glasgow Med. Jour.*) has found nothing more useful, both for adults and children, than the following; R. Potass. bicarb., ℥ iij.; tr. hyoscy., ℥ iij.—℥ iv.; spt. æth. nitrosi, ℥ ss.; spt. chlorof., ℥ ij.—℥ iij.; aq. ad. ℥ xij. M. And R. Acidi citrici, ℥j.—℥ ij.; aq. ad. ℥ vj. M. Sig. Two tablespoonfuls of the former mixture to be taken with one of the latter during effervescence every three or four hours (for an adult). If the secretion be profuse and the heart's action weak, he has often found the following mixture useful: R. Acidi nitrici dil., ℥ ij.; tr. bellad., ℥ ij.; spt. chloroformi, ℥ ij.; aq. ad. ℥ xi. M. Sig. Two tablespoonfuls every four hours (for an adult). "In dealing with children, it is well to bear in mind that, if the amount of secretion be excessive and embarrasses the breathing, a timely stimulating emetic, such as carbonate of ammonia, or mustard, often proves invaluable. This now brings us to the stage approaching convalescence, in which such drugs as quinine, vegetable bitters, steel, nux vomica, and the dilute mineral acids all have their uses; and when convalescence has become established, I am of opinion that if we can get our patient persuaded to take cod-liver oil for a month or two, it has the effect of preventing a fresh attack.—*Med. and Surg. Reporter.*

A NOVEL METHOD OF BLEEDING.—The *Brit. Med. Jour.* notes the relief of a case of cerebral congestion through blood-letting by means of a novel device. The patient, a fat, plethoric lady, fifty years of age, came under the charge of Chas. Coppinger, F.R.C.S.I., and at the time of the surgeon's visit was in a condition of stupor, out of which she could be roused with some effort, but only to relapse into sleep again. Her breathing was heavy, and she presented all the symptoms characteristic of an overloaded vascular system. The indications for treatment were plain, and leeches not being obtainable, depletion by means of venesection was proposed. The friends of the patient, who were ladies, gave their consent, but were horrified at the suggestion of so barbarous a proceeding, and Mr. Coppinger anxious to spare them the sight of blood, then and there conceived the idea of substituting the aspirator for the lancet. The patient, who had not long before been treated for hemicrania by hypodermic injections of morphia, was roused up and told that the needle was about to be "inserted into the skin of her neck, to which she at once consented." The needle of the aspirator was then passed into the external jugular

vein, which was much distended, and four ounces of blood were withdrawn without difficulty. The result of this trial being satisfactory, the surgeon repeated the operation in the course of a half-hour, abstracting six ounces more of blood. The patient was speedily relieved of her alarming symptoms, and neither she nor her attendants suspected that she had been bled, until the procedure was subsequently explained to them.—*Med. Record.*

IRON HYPODERMICALLY IN ANÆMIA.—Dr. J. M. Da Costa is using hypodermic injections of iron for anæmia, in a case of combined malarial toxæmia and lardaceous disease of the viscera, including the intestinal glands. To the other solutions for this purpose he prefers a double salt produced by the addition of pyrophosphate of iron to a solution of citrate of sodium. Two grains of the salt, in this form, are given every day, varying the points of puncture, but generally administering it under the extremities; in this form no abscesses have been observed. With other solutions of iron, including dialysed iron, abscesses were quite common even with every precaution as to the cleanliness of the syringe. In a case last winter of idiopathic anæmia (pernicious?) these injections not only arrested the patient in a downward course, but actually worked such a change that his strength and appetite returned and he was afterwards discharged in good health. This case is not called pernicious anæmia because the patient did not die; but if an opinion could be based upon the previous course of the disease, and his chlorotic condition at the time of the change in his treatment, no other diagnosis and no other prognosis would have been entertained than that mentioned, by any ordinary observer.—*Boston Medical Journal.*

HYSTERICAL PSEUDO-PHTHISIS.—The *Practitioner* (Dec., 1883) reproduces from *Centralblatt für Gynâcologie* (Sept. 8th) an article by Dr. Fabre describing a condition simulating phthisis often found in young women suffering from chlorosis and hysteria. There is a cough, with expectoration, and even spitting of blood. Physical examination reveals dulness at the apex (usually on the right side), feeble respiration, and occasional râles. The author regards these symptoms as due to a vaso-motor disturbance exciting a pulmonary congestion. Other organs may also be subject to functional disturbances. Obstinate anorexia, gastric pain, occasionally diarrhœa, but more frequently constipation, are not seldom present. The pulse is weak and frequent, like that of fever, although the temperature may be normal. Sometimes, however, there is elevated temperature, but it is only transitory, and regular evening exacerbations are never observed. The expectoration is not purulent, but may be mixed with blood. While in true phthisis there is emaciation, in these cases the

patients often increase in weight. Sweating, as a rule, is not met with.

The differential diagnosis is often difficult, and the author relates that cases have not infrequently occurred in which a diagnosis of pulmonary consumption was made, but the patient nevertheless recovered. The condition may exist without material improvement for months, or even years.—*Bost. Med. and Surg. Four.*

WOUND OF LUNG—RECOVERY.—On the morning of Nov. 2nd, I was called to see P. R., of Ballylanean, who was suffering from a stab inflicted with a penknife, some hours previously. On making a careful examination I discovered five wounds, four of them were insignificant, but the fifth penetrated deeply between the eighth and ninth ribs on the left side, leaving an opening from which a piece of lung, about three and a half inches long, was protruding. An attempt to reduce it failed, owing to the wound constricting the protruding portion; having therefore put on a piece of wet lint and a bandage over it, I allowed it to remain and slough of its own accord, which it did on the twenty-second day after the receipt of the injury. After the third or fourth day, I employed carbolic oil, owing to the fœtor of the discharge, and continued its use until the portion of lung had come away. Then the wound healed rapidly with zinc and carbolic ointment. On the twenty-fifth day after the injury, I allowed the patient to get up, and since then he has been able to return to his ordinary occupation, without any interference with the movements of the chest. All through there were no bad symptoms, the pulse never going above 100 beats in the minute, nor the temperature above 99° Fahr. This was remarkable, as the man used to drink freely; but in the treatment I kept him strictly low, refusing to allow him stimulants of any sort.—A. H. Hayes, *Brit. Med. Jour.*

IODOFORM IN COMPOUND FRACTURES.—Prof. Mosetig, of Vienna, while irrigating the wound with pure water, removes all clots and spicula of bone and coaptates the fractured ends, resecting them if necessary. After drying the wound, he throws a thin layer of iodoform into the medullary cavity by means of an insufflator. He then passes into the wound an emulsion of iodoform, for instance: *R.* Iodoform subtil. pulv.; glycerini, *aa* 20.00; aq., 10.00; g. tragacanth, 0.15. *M.* Exact. *f.* emulsio. This runs into all the little pockets of the wound.

The fragments are adjusted, metallic sutures being used when necessary; drainage tubes are introduced and the whole covered with a layer of iodoform gauze (50 per cent.) and this is covered with cotton. The first dressing can remain unmolested for three weeks or longer, unless fever occurs (the aseptic fever of the first day not in-

cluded). With the above dressing, Mosetig treated successfully, within the last two years, thirty-seven compound fractures without even having noticed continued septic symptoms.—*St. L. Med. and Surg. Four.*

GASTROTOMY AND DILATATION OF THE ŒSOPHAGUS.—On October 24th last, Professor Loreta performed, in the surgical clinic of Bologna, a new and important operation—dilatation of the Œsophagus from the stomach. The patient was suffering from stricture at the lower third of the Œsophagus, produced by extensive cicatrization, the consequences of swallowing caustic potash. The site, nature, and degree of the stricture were such as to render useless any operation undertaken by the mouth. The patient was reduced to an extreme degree of emaciation, from the impossibility of taking sufficient nourishment. Gastrotomy was performed, and a passage secured for the introduction of the dilator into the stomach; it was then pushed up the Œsophagus, and the stricture thoroughly dilated. The operation only lasted half an hour, and was most successful; on the first day, the patient was able to swallow food easily. The incisions united by first intention; there were no signs of peritonitis; and, on the fourteenth day, the patient was well. The sound passed without difficulty, and, probably, its periodical employment will render the cure permanent. On November 4th, Professor Loreta also successfully performed dilatation of the pylorus, in a young woman aged 26.—*British Medical Journal.*

BROMIDE OF ARSENIC IN DIABETES.—Dr. Pekai, clinical assistant to Professor Karaonyi of Buda-Pesth, from a series of experiments with bromide of arsenic in diabetes, proves the remedy to be exceedingly satisfactory. He uses a solution prepared as follows:

R. Arsenious acid.

Carbonate of potash.

Bromine..... *aa* gr. jss.

Water..... *q. s.*

The arsenious acid and potash are placed in an eprouvette, five drops of water are added, and treated until the liquid is limpid. Then sufficient water is added to make two and a half drachms by weight, and then the bromine and the whole let stand for twenty-four hours before use.

The solution was administered by placing three drops in an ounce of water, of which three equal doses were made. The quantity being increased, an additional drop every three days until ten drops a day were administered.

REMEDY FOR BURNS.—During a recent visit to a patient in an adjoining town, I was hastily summoned to see a woman badly burned (while lighting a fire with coal oil) on the hands, arms, and

around the body where her clothes were fastened to her person. Not having any of the ordinary remedies at hand, except cold water, which *en passant*, is one of the best where it can be properly applied, I mixed hog's lard with *four times* its weight of common bread soda (the bicarbonate), which is used here in the homes of many for mixing with the dough in bread-making, and applied it as a salve to the burned parts, and I never saw a case of the kind do better under any treatment. The wounds were kept well covered with it, and they all healed very nicely without inflammation and with very little suppuration. Indeed, they seemed to *dry up* under it. I shall try it in the future in all similar cases, until I find something better.

CERVICAL ENDOMETRITIS.—Boracic acid is highly recommended by Dr. W. H. DeWitt in the treatment of cervical endometritis (*Cinn. Lancet and Clinic*). He cites a case in which, after going through the entire list of remedies used in such cases, he determined to test the value of boracic acid. Moistening a camel's hair pencil and covering it with the powder, it was carried as high up as possible; at the same time the convexity of the neck was also covered with the acid, on account of excoriation. Four days later there was very decided improvement, and the acid was then applied by packing the cervix with it as firmly as admissible. The patient was directed to elevate the hips and remain in that position for two or three hours, in hopes that some of the acid would find its way to the parts above the cervix. In one week, another examination was made, when it was found that all inflammation had disappeared.—*Weekly Med. Record*.

SUBCUTANEOUS INJECTIONS OF ETHER.—Dr. C. E. Sheely (*Brit. Med. Jour.*, Nov. 17, 1883) has had good results from its use as a stimulant. The dose is from fifteen minims to half a drachm. He thrusts the needle through the true skin and superficial fascia, and then enters it for about three-quarters of an inch parallel to the surface. He has never seen abscesses result. As ether is a ready solvent of fat, it is advisable to look to the leather packing of the piston of the syringe as soon as possible after using it, and to re-oil it. The ether also attacks the cement used to secure the mouth to the glass barrel, and they will, sooner or later, become loose. Moreover, as it acts upon "celluloid," a syringe made of this material should not be used.—*Med. & Surg. Reporter*.

A NEW CURE FOR BUNIONS.—To the New York Pathological Society (New York *Med. Jour.*, Dec. 15, '83) Dr. L. H. Sayre presented some metatarsal bones which had been removed from either foot for bunion. The patient was a man about forty

years of age, in whom the condition of the foot, which had existed for many years, gave rise to much difficulty in walking, and on two occasions had caused suppuration. The metatarsal bone was removed by means of a bone forceps through an incision on the dorsum of the foot. The incision was closed with black silk, the wounds united in less than two weeks, and the patient was now able to get about with comfort and had a movable joint.—*Med. and Surg. Reporter*.

THE HYPODERMIC SYRINGE.—Dr. Frank D. Stephens reports in the *Medical Record* that he has had no trouble with his hypodermic syringe since he adopted the method of adjusting a rubber tip to the lower extremity of the syringe. For this purpose he uses the upper two-thirds of a common rubber tip, such as is found on an ordinary medicine-dropper. In this way the syringe is kept airtight, and if care is taken to leave a little liquid in the syringe after using, the packing will remain moist and pliable for a long time.

LOCAL ANÆSTHESIA.—According to the *Medical News*, local anæsthesia may be readily produced by applying with a camel's hair brush the following mixture:—

R Chloral,	
Camphor,	aa 3 j,
Morph. sulphat.,	3 ss,
Chloroform,	3 j. M.

Sig.—To be applied with a brush to the area to be incised.

"URSU-OSIS."—It is said, and probably with truth, that the year never ended with so many persons made actually sick by the bearish condition of the market. Melancholia, general nervous asthenia, with occasionally sugar in the urine, seem to be the characteristic features of a condition which we may term "ursu-osis." About seventy per cent. of all railroad presidents, ironmen, and buyers on margin are now affected with it.—*Med. Record*.

A CASE OF DEATH FROM THE INHALATION OF ETHER occurred at a clinic at Bellevue Hospital recently. The patient was a boy with apparently sound lungs and heart. He was under ether for about an hour and a half when he suddenly ceased to breathe, and all efforts at resuscitation failed.—*Med. Record*.

A MAN WHO ABSTAINS FROM LIQUOR, as shewn by insurance tables, at 20 years of age has a chance of living 44.2 years; at 30, 36.5 years; at 40, 28.8 years. An intemperate man's chance at 20 is 15.6 years; at 30, 13.8; at 40, 11.6.

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

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TORONTO, FEBRUARY, 1884.

The LANCET has the largest circulation of any Medical Journal in Canada.

THE SPREAD OF MEDICAL KNOWLEDGE.

We have been much surprised and gratified at the widespread interest that is taken by newspaper readers, comprising of course the majority of the population, in medical science, when that science is brought within the scope of their comprehension. Should any one be inclined to doubt the fact, let us take up a well known Toronto daily of the date at which we are writing—an entirely hap-hazard method of proving our assertion—and see what we find:—

Temperance in Sweden; tea-leaves for burns and scalds; dressing and undressing the sick; cure for styes; how to tell diphtheria; how to cure a cold; Canon Farrar on temperance; milk fever; tar for burns and scalds.

All these, exclusive, of course, of advertisements, are inserted in one issue of the usual eight pages, at a time when there is an actual plethora of news—Orange riots; war in the Soudan; France and China; election returns; controverted elections; trades congress; Exchange Bank; the University question; cable news; etc.

Here, again, is a paper of a totally different type, one devoted to trade; the first we happen to lay our hands on is *Cotton, Wool and Iron, and Boston Journal of Commerce*, of the date of October 6th last. In this we find the following.—

Lotions to prevent chilblains; salicylic soap; dichloroacetic acid for warts; treatment of snake bites; rational dress reform; tobacco smoke; hydro-quinidine and quinidine; hydro-bromic acid;

solidified bisulphide of carbon; the mush disease (a column and a quarter—about twelve hundred words); the remedies of nature (three columns and a half—about thirty-three hundred words).

Thus throughout the whole of the periodical literature of the present day, a very large part of what is technically known as *padding*—that is matter other than late news, which would suffer from delay in insertion—is composed of the thoroughly practical, sensible ventilation of the sources, prevention and cure of perhaps minor, but truly important maladies. It is not, of course, recondite and intricate problems of medicine and surgery that are discussed—one would not expect in our daily papers abstruse discussions on ligation of the carotid or the transfusion of blood—there would soon be an outcry against that; but it is generally to those slight divergences from health, which make up indeed the majority of ailments, that attention is paid. Such, for example, as the results of the variations of temperature, inefficient or unscientific wearing apparel, innutritious food, insufficient exercise, disregard of cleanliness, deprivation of fresh air, etc.

Attentive readers have also doubtless observed that the newspaper press has not unfrequently made insinuations and complaints against the medical profession for the exclusiveness with which, it is said, they devote their attention only to the higher branches of medicine and surgery. Nor is this a phantom only, for in several instances these complaints have found definite utterance.

Another and fruitful source of the inuendoes we have remarked upon was the practice in former years—falling happily into comparative desuetude in the present day—of clothing all medical utterances in the technical language of the schools. This did much to foster the habit of looking upon the profession as a somewhat pedantic and supercilious body of men.

The fact, then, to which we would point those who indulge in such complaint is, that all this vast mass of useful medical knowledge, imparted to them gratis in the pages of their daily paper, is in reality the production of that profession which they assert is remiss in its duty in this very direction. This is the point that is overlooked. Fifty per cent. of this useful scientific knowledge is anonymous; ninety per cent. of it is probably clipped from purely medical magazines (of which the

Newspaper Directory shows there are above a hundred in the United States alone); and since each paragraph is not signed by an M.D., etc., the source from which it is obtained is unnoticed and unknown. Again, for these trivial ailments, a medical practitioner is rarely consulted. He has, therefore, rarely an opportunity of expressing verbally the genuine interest which he may truly possess in minor affections, and none whatever in the way of pointing out preventive measures.

We would therefore most emphatically point out that for all this knowledge in regard to the cure of disease, the public is indebted to that large class of thoughtful and philanthropic men, learned in all the known laws of nature, who are daily spending much time and money in investigating the commonest affections of everyday life, and gratuitously publishing the results of their research.

THE MEDICAL LIBEL CASE.

This was an action for alleged libel instituted by Dr. Lennox, one of the physicians of the "International Throat and Lung Institute" of this city, against Drs. McCammon, of Kingston, and Bray, of Chatham, members of the Ontario Medical Council, for statements made by them at the meeting of the Council in June last, and reported in the *Mail* newspaper of that date. At this meeting the question of appointing a public prosecutor came up for discussion, during which special reference was made to Drs. K. & K. and Souvielle, of "Spirometer" fame, as quacks; also that Canadian physicians, who hired themselves to quack American firms, who were thus enabled to practice under cover of a Canadian practitioner's license, were also practically quacks. Dr. McCammon, it is alleged, referred to such parties as "medical prostitutes who were a disgrace to the profession," and prevented the bringing of 'he quacks to justice. Dr. Lennox, who is a licensed practitioner, felt himself aggrieved by Dr. McCammon's remarks, and sued for \$10,000 damages, for defamation of character, claiming that the statements made injured him personally and in his profession.

The defence in the action was that the plaintiff was not mentioned, inferentially or by name, and the defendant, Dr. McCammon (whose case was the first called), was not at that time aware of the existence of the "Throat and Lung Institute,"

and also that he did not use the words given in the *Mail's* report, although they were, to that effect. The case was tried before Judge Rose—Dalton McCarthy for the plaintiff, and Christopher Robinson for the defendant. Dr. Lennox, the principal witness in the prosecution, was rather severely handled by the counsel for the defence with reference to the extravagant statements published in the advertising columns of the *Mail* and other papers. The statements referred to, the witness claimed, were written by "Souvielle." A number of medical men were present during the trial, and considerable interest was manifested in the case. The ruling of the judge in the matter of privilege on the one hand, and the necessity of proving malice on the other, was not satisfactory to the counsel on either side, and they consequently agreed that his Lordship should enter a verdict for the defendant, and allow the points of law to be argued before a full bench, with leave, in case the judge's ruling is not sustained, to enter a new trial. We have no doubt this will be the end of the matter, and we congratulate Drs. McCammon and Bray on the result. They were but doing what they conceived to be their duty in the position in which they were placed. We believe these actions were instituted more with a view to a free advertisement for the "Spirometer men" than for any other purpose, and if they are satisfied with the result of the trial in this respect after the report in the *Mail*, the general profession, at all events, has no occasion to complain.

Inasmuch as the defendants have been put to great expense, inconvenience and loss of time, in defending these suits, and as they were acting in a public capacity, and in the interest of the general profession when the alleged libellous statements were made, we think their expenses should be borne by the Medical Council. As an example of how such things are done across the Atlantic, we would refer to the "Bower and Keates' case."

THE BOWER AND KEATES' CASE.

The case of civil and criminal prosecution against the above named gentlemen has stirred to its very depths the fraternal sympathy, and called forth the moral and pecuniary support, of our professional brethren in England. In the autumn of 1882, Drs. Bower and Keates performed the opera-

tion of tracheotomy upon a child suffering from diphtheria, but the disease progressed rapidly to a fatal issue. Shortly after the trachea was opened, the tracheotomy tube became choked with a portion of membrane, and the father of the child was asked to remove the obstruction by oral suction. This he did, but unfortunately contracted diphtheria, and to compensate himself for his pecuniary loss in consequence, brought an action for damages against the medical attendants. The result was that the jury was discharged without giving a verdict, and a new trial was instituted.

A few months ago, nearly a year or so after the alleged offence, a criminal action was instituted against the defendants, for having through gross and criminal negligence sacrificed the life of the child. The specific points were: that the temperature was not taken; that the throat was not examined; that chloroform was not given; and that proper stimulants and proper diet were not ordered. It is not at all necessary to remark upon the frivolous and vexatious nature of the charges, suffice it to say, that after five days' hearing of the charge of manslaughter, the presiding magistrate dismissed the case without calling upon the defence, remarking that he would not only be sanctioning a prosecution but a persecution as well, if he allowed the case to proceed. The medical gentlemen in question came out of the ordeal not only with their reputations unstained, but with the esteem and sympathy of their medical brethren both felt and expressed as may be seen by reference to the large and generous subscriptions to the "Indemnity Fund" which have been forwarded by their confreres in all parts of the kingdom, to defray their expenses. Upwards of sixteen hundred letters containing subscriptions varying from £10. 10s. to 2s. 6d. each, have been received by the secretaries, amounting in all to fifteen or sixteen hundred pounds sterling. The *Lancet*, in commenting on this case says:—"As a matter of history, the primary impulse to this movement came from two members of the College of Physicians—its honored President, Sir Wm. Jenner, and Dr. Moxon. The President felt that the College as a college had no funds out of which to help Messrs. Bower and Keates. But he remembered that there is one source of power and sympathy greater than the corporations—the profession itself. He rightly judged, too, another factor in this successful move-

ment, which it would be alike ungenerous and absurd to ignore—the willingness of other representative members of the profession to co-operate with himself and with the profession in any course for vindicating the honour of medical men. It would be invidious to single out names where all have done so well. The result must be very gratifying to those who led the way. It must beget the conviction that the profession only needs to be well led to act with union and with effect, and that it would be no great misfortune if the "persecution" of an occasional martyr or two like Messrs. Bower and Keates gave an opportunity for showing the solidarity and strength of the medical body. As to our own part in this matter, it is not for us to speak. The credit due to us is only that of estimating rightly the too little recognised forces of professional sympathy and interest. Hitherto there has been nothing in the organization of our profession to connect its members one with another, or with its principal corporations. We must hope for better days in this respect. Meantime the movement on which we comment shows that the profession is one, and would act with infinitely more effect if it could be more consolidated."

JOHN REDDY, M.D., L.R.C.S., I.

The sudden and unexpected death of Dr. Reddy, of Montreal, which took place on the 23rd ult., in Dublin, whither he had gone on a visit, was a painful surprise to his friends and relatives in Canada. He left Montreal in June last, for a tour of the continent and a visit to his native land, for the benefit of his health. He travelled through England, Germany, France and Italy, and returning to Ireland, proceeded to Dublin, where he died. Dr. Reddy was a graduate of Dublin, and practised his profession upwards of thirty years in Montreal. For twenty-five years he occupied the position of surgeon to the Montreal General Hospital, and was widely known and highly esteemed in his adopted city. He received an *ad eundem* degree from McGill College in 1856, and was a representative Fellow in medicine for eight years. He was appointed Surgeon to the Montreal Garrison Artillery in 1864. He was elected President of the Medico-Chirurgical Society in 1874, and was assessor to the medical faculty of Laval for several years.

He took no part in public affairs, but confined himself strictly to his chosen profession, and was a most successful practitioner, highly gifted, and of an exemplary character. Deceased was sixty-two years of age at the time of his death. He leaves a large family, his eldest son, Dr. H. L. Reddy succeeding to his extensive practice.

NEW MEDICAL JOURNALS.—We have received the first number of the *Kansas City Medical Record*, a new aspirant for professional favor in the Western States. It is edited by Drs. Fulton and Halley (Canadian graduates, both), and presents a most creditable appearance. The subscription price is \$3 per annum. In view of the large number of miserable cheap-John trashy medical periodicals published in the United States within the past few years, we are pleased to see a new departure in the right direction. Outside of those published in the large cities, this is the best medical journal in the United States.

The *Archives of Pediatrics* is a new journal edited by Dr. Watson, of Jersey City, devoted, as its name indicates, to diseases of infants and children. It is also a most creditable production and published at a price which is a guarantee of respectability, viz. : \$3 per annum. We are pleased to see the name of one of our Canadian confrères, viz. : Dr. Blackader, of Montreal, associated with the editor as one of the collaborators.

The *Analectic*, a monthly epitome of medicine and surgery, edited by Dr. Wells, and published by Putnam's Sons, New York, at \$2.50 per annum, is also a promising journal. We gladly welcome all the above to our exchange list.

BATHURST AND RIDEAU MEDICAL ASSOCIATION.—The semi-annual meeting of the above association was held in Ottawa, on the 9th ult., Dr. Malloch, Vice-President, in the chair. The attendance was small, owing to a severe snow storm. After routine, the secretary read a telegram from the secretary of the Provincial Board of Health, intimating that it was proposed to hold a sanitary convention in Ottawa. This was received with favor by the members present, and a resolution was passed, promising the aid of the association in preparing papers and making arrangements to secure a successful meeting.

A paper was read by Dr. Grant on "Urethral

Stricture," based on a case successfully treated with Holt's dilator. Dr. Small read the report of a case of multiple birth, three fœtuses being expelled, one fully developed, the other two blighted at about the fourth month. The patient had been in poor health, but no sign of uterine irritability occurred until the last month before delivery. Cases of miscarriage were reported by Drs. Fraser and Wallace, and one of Placenta Prævia by Dr. H. P. Wright. A lengthy discussion followed upon hemorrhages during gestation. In the evening the members dined together, the usual toasts and speeches being indulged in.

ONTARIO MEDICAL COUNCIL CURRICULUM.—The following changes have been recommended by the committee appointed to consider the matter : 1. Natural Philosophy is to be added to the subjects for matriculation, and that 60 per cent. of the maximum marks be required of candidates for pass in the following subjects, viz. : English Grammar, English Literature, Composition, Dictation, History and Geography ; 40 per cent. in Arithmetic, Algebra and Euclid ; 50 per cent. in Natural Philosophy, and 33 per cent. in Latin. 2. The clause relating to the exemption of graduates in Arts from one year's study and the examination in Chemistry, is struck out. 3. In the subjects of the primary examination, Botany is struck out ; Pharmacy is substituted for Therapeutics, and the candidate will be required to present a certificate of proficiency in making and mounting microscopic specimens. 4. Therapeutics is added to the subjects of the final examination. Candidates must also present certificates of attendance upon six post mortems, and ability to draw up a report of same ; also a certificate of reporting satisfactorily six cases each in clinical medicine, and clinical surgery.

BROMIDIA.—Prof. C. H. Hughes, Lecturer on Psychiatry and Neurology, Post-Graduate Faculty, St. Louis Medical College, Editor *Alienist and Neurologist*, etc., says in the December No., 1882, of that journal : "Bromidia is a reliable compound of well-known and favorite medicines in the management of insomnia, and as such we commend it to those of our subscribers, hospital physicians and others, when occasion requires the employment of this combination of the potassic bromide, cannabis indica and chloral hydrate. We have always found

the compound *uniform* in composition, the mixture well made, and the therapeutic effect what ought to be expected from its ingredients."

PARLIAMENTARY AND MUNICIPAL HONORS.—We give below the names of medical men who have been elected to important positions: Hon. Dr. Ross, *Premier* of Quebec. Dr. Dowling, *member* of the Ontario Legislature for S. Renfrew. Dr. McCammon, *Mayor* of Kingston, also Drs. Rae, Oshawa; Bogart, Whitby, and Standish, Palmerston, Ont. Dr. Willoughby, *Reeve* of Colborne and *Warden* for Northumberland and Durham, also as *Reeves*, Drs. Mitchell, Wallaceburgh; Bradley, Kincardine; Allan, Arthur; Mearns, Petrolea; McConnell, Brockton. As *Councillors*, Drs. Harris, Brantford; Cook, Chesley; Black and Bascom, Uxbridge; Webster, Esquering; Gillespie, Cannington; Henry, Harriston; Goodman, St. Catharines; Scott, Southampton; Tennant, Lucknow; Doherty, Markham; Aikman, Windsor; Walker, Dundas; Mathieson and Sinclair, St. Marys, Ont.

SPASMODIC TORTICOLLIS.—Dr. Sands of New York (*Annals of Anat. and Surg.*) reports two obstinate cases of this affection which were greatly benefited by excision of a portion of the spinal accessory nerve. He made an incision three inches in length along the anterior margin of the sterno-mastoid, commencing near the mastoid process. The muscle was drawn outwards, and the nerve exposed where it crosses the internal jugular vein. A portion of the nerve one-fourth of an inch in length was excised, and the wound dressed in the usual way. The improvement was gradual in both cases.

APPOINTMENTS.—Dr. F. S. Greenwood has been appointed attending physician to the St. Catharines Hospital. Dr. Griffin has been elected President of the Medico-Chirurgical Society of Hamilton. Dr. T. C. Brown, of Fredericton, N. B., has been appointed Surgeon of the Fredericton Military School. Dr. J. S. Lathern has been appointed as one of the physicians to the Halifax Dispensary, *vice* Dr. D. A. Campbell, who retires voluntarily. Dr. Kenneth McKenzie, formerly of Melbourne, Que., has been appointed Prof. of Anatomy in Williamette University, and Surgeon to St. Vincent's Hospital, Portland, Oregon. Dr. W. H. B. Aikins has been appointed physician to the House of Providence, Toronto.

SEQUELÆ OF SUNSTROKE.—In the treatment of the sequelæ of sunstroke such as headache, dizziness, mental dulness, and sometimes insommia, which are due to chronic meningitis, Dr. H. C. Wood, of Philadelphia, recommends heroic doses of iodide of potassium, and the application of the actual cautery to the nape of the neck. He uses Paquelin's and applies it repeatedly until he has cured the disease. He also applies antimonial ointment for a few hours on the raw surface. The patient is also sent to a cool climate in the summer time.

On several occasions we have received samples of sugar-coated pills and granules manufactured by W. R. Warner & Co. of Philadelphia. We have also used them in our practice for several years past and can speak in the highest terms of the reliability and efficacy of these standard pills. All their preparations are equally reliable. The pills and granules prepared by this firm are beautiful specimens of pharmaceutical art, and being made from the purest drugs, and with the utmost care, may be confidently relied upon.

CALLING A MEDICAL MAN.—The following item is worthy of note:—The residents of Lambton Mills recently held a meeting to consider the advisability of extending a call to a medical man to fill the vacancy caused by the death of Dr. Beatty. A deputation was appointed to wait on Dr. Cotton, of Burnamthorpe, and ask him to settle in Lambton Mills, Ont.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.—The annual meeting of this society was held on the 25th ult. The following officers were elected:—President, Dr. Powell; Vice-Presidents, Drs. Harvey and Small; Secretary-Treasurer, Dr. Grant, jr.; Council, Drs. Grant, H. P. Wright, S. Wright, Robillard and Macdougall. Dr. Scott, of Hazledean, read an interesting paper on *Empyema*, which will be published in a future issue.

REMOVALS.—Dr. Rose has removed from Simcoe to Waterford, Ont. Dr. C. J. Chipman, of Cardinal, has removed to Ottawa. Dr. B. F. Hurdman has returned from England, and settled in Inverness, Que. Dr. J. Smith has removed from Emerson, Man., to Portland, Oregon. Drs. T. and C. Duncombe have commenced practice in St. Thomas, Ont.

Dr. O. S. Winstanley, of this city, has gone to Southern California for the benefit of his health.

NEW REGULATIONS FOR THE L. R. C. P. EDIN.—Canadian graduates who propose going up for the L. R. C. P. Edin. will in future be required to pass a written, as well as an oral examination in medicine, midwifery, materia medica and forensic medicine. This change came into effect in January, 1884.

DIPHThERIA IN THE MARITIME PROVINCES.—This disease still continues to prevail in certain parts of the fair provinces by the sea. Dr. W. D. McKenzie, of Parrsboro, N.S., lost two children recently, within a few days of each other, from this terrible scourge. The Dr. has our deepest sympathy in his sad affliction.

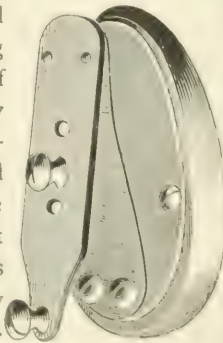
PRIMARY FOR M. R. C. S. ENG.—The following gentlemen have passed the primary examination before the Royal College of Surgeons, Eng.: Drs. W. G. Anglin and G. H. Denike, (Kingston), E. M. Hewish, (Toronto).

CORONER.—Dr. A. W. Campbell, of Gravenhurst, Ont., has been appointed Coroner for the District of Muskoka.

New Instruments.

A NEW TRUSS.

We have been shown a new truss, invented by Messrs. Authors & Cox, manufacturers of surgical appliances, 91 Church-st., Toronto, which we believe will commend itself to the judgment of the medical profession, and will occupy a front place among trusses. We do not know of any truss that can successfully compete with it. The inventors do not claim that it will answer in every case, for there are many ruptures that cannot be retained except by a truss made to order and specially adapted to the case in hand. What they do claim is, that it will suit the great majority of ruptures. The chief improvement lies in the pad, which, as may be seen by the cut has a flat spring, which is secured by one end to the lower part of the pad, the upper end being fastened to a lever, which gives the spring a double action. The pelvic belt is secured by a stud in



the centre of the lever, so that the pressure of the pad is directly upward and inward, and owing to the spring being secured at the bottom of the pad and the upper part free it is never pulled out at the top, but under all circumstances lies flat against the abdomen. The spring compensates for any change in the position of the body. This very desirable object is not attained by any other truss that we have ever seen. In all other trusses the upper part of the pad stands out from the body, when the abdomen is flattened as in lying down.

Books and Pamphlets.

A TREATISE ON SYPHILIS IN NEW-BORN CHILDREN AND INFANTS ON THE BREAST. By P. Diday. Translated by G. Whitley, M.D., with Notes and Appendix by F. R. Sturgis, M.D. W. Wood & Co.'s October issue.

This is a valuable book, though only an English version of an old one, for in modern medicine a quarter of a century is a very great age for any book to attain and still command the attention of the profession. The reader will however find it is not all old, for the American editor, Dr. Sturgis, whose experience in venereal and skin diseases has been very large, has introduced much valuable original matter. In some places, indeed, where he has found it necessary to correct the statements of the author, we have felt inclined to think it might have been as well to have left these out, for it is rather wearying to readers to wade through long pages, and at the end find that these are cut into mince-meat by the reviser. Perhaps Dr. Sturgis will, on reflection, think it would have been better to have reproduced just so much of Diday's book as he deemed accordant with the present advanced stage of syphilography, and he no doubt could have instructively filled up the required pages with materials at his own command.

Now that the subject of inherited syphilis is every day forcing itself more and more on the medical practitioner, books of this class are indispensable, for it is an undeniable fact that the evil treated of is of great extent, and in numerous instances of fearful intensity.

A PRACTICAL TREATISE ON MATERIA MEDICA AND THERAPEUTICS. By Roberts Bartholow, M.A., M.D., Prof. of Materia Medica, etc., in Jefferson

Medical College, Philadelphia. Fifth edition, revised and enlarged. New York : D. Appleton & Co. Toronto : Willing & Williamson.

The work before us has undergone many important changes and additions in the present edition. The use of electricity in medicine has received the author's special attention, and much light has been thrown on the subject and many valuable hints suggested. The work is brought fully abreast of the most recent advances in this department. The various new remedies recently introduced to the notice of the profession are brought under discussion, such for example as nitro-glycerine, muscarine, quebracho, convallaria, resorcin, chinoline, etc. The value of atropine as an antidote to poisoning by carbolic acid is alluded to, and the credit given to Dr. Post, of New York, for having first suggested it. The work contains a fund of valuable information, not to be found in works of the kind generally, and we have therefore much pleasure in commending it to the attention of the profession in Canada.

THE MEDICAL CHEMIST'S MANUAL OF CHEMISTRY. By J. H. Atthaus, A.M., M.D., Prof. of Chemistry and Toxicology in the University of Buffalo, and of Physiology in the University of Pennsylvania. Edited by Dr. J. H. Wood & Co. of Philadelphia. Willing & Williamson.

As is seen in the preface, "the author has striven to regularize a work which should contain as much as possible of those portions of special chemistry which are of direct interest to the medical practitioner, and at the same time to exclude as far as possible, without detriment to a proper understanding of the subject, those portions which are of purely technological interest." The work is divided into three parts: the first treats of the principles of the science; the second treats of special chemistry; and the third is devoted to laboratory technics. The author has succeeded well in his efforts to make the work as simple and practical as possible, and we feel sure he will receive the grateful acknowledgments of those whose interests he has so well considered.

A MANUAL OF THE OPERATIONS OF SURGERY, for the use of Senior Students, House Surgeons and Junior Practitioners. Illustrated. By Joseph Bell, F.R.C.S., Edin., Lecturer on Clinical Surgery, Edinburgh University. Fifth edition, revised and enlarged. Edinburgh: Maclachlan & Stewart.

We are pleased to receive from the publishers an advance copy of this most excellent little man-

ual on operative surgery by the distinguished surgeon, Joseph Bell. The author very modestly claims that it is for the use of students, house surgeons and junior practitioners, but we venture to say that it will be found of service to all surgeons whatever their experience may be. The descriptions of the various operations, though concise, are yet sufficiently explicit, and many useful and valuable hints are given with regard to their performance, and the reasons for the selection of one operation in preference to another, which are not to be found in other works on surgery. We have much pleasure in commending the work to the attention of our readers.

THE PATHOLOGY AND TREATMENT OF VENEREAL DISEASES. By Freeman J. Bumstead, M.D., LL.D., late professor of venereal diseases at the College of Physicians and Surgeons, New York; and Robert W. Taylor, A.M., M.D., professor of venereal and skin diseases in the University of Vermont, etc. Fifth edition, revised and rewritten, with many additions by Dr. Taylor, with one hundred and thirty-nine wood cuts and thirteen chromo-lithographic figures. Philadelphia: Henry C. Lea's Son & Co. 1883.

This work is already well-known to the profession, and the present edition, edited by Dr. Taylor, will be gladly welcomed. It is not too much to say that it is the best work on venereal diseases in the English, or indeed in any language. The style is clear and distinct, and the teaching quite abreast of the most advanced ideas on the subject of which it treats. Mercury still holds a prominent position, and justly so, in the treatment of syphilis. This is in accord with the experience of the profession in all parts of the world. The publishers have also done their part well.

PARKES' MANUAL OF PRACTICAL HYGIENE. Sixth Edition, by Professor Chaumont. New York: William Wood & Co. Toronto: Willing & Williamson.

Professor Chaumont has already won a high reputation as editor of the great work of his predecessor Dr. Parkes, late Professor of Military Hygiene in the Army Medical School at Netley; and in some particulars this Sixth Edition is an improvement on the previous ones. Matter now out of date has been omitted and new substituted, but without any great increase in size of the work.

Every aid of type arrangement and classification has been made, and in this reprint of Wm. Wood

& Co. (Wood's Library), an appendix will be found of American practise in matters relating to Hygiene, by Fred'k N. Owen, Civil and Sanitary Engineer.

Unhesitating confidence may be placed in this work as one of reference by the practitioner.

HINTS IN SICKNESS: WHERE TO GO AND WHAT TO DO. By Henry C. Burdett, Founder of the Home Hospitals Association for paying patients. London: Kegan Paul, Trench & Co., Paternoster Square.

This unpretentious little work contains a good deal of valuable information upon the terms of admission to hospitals, asylums, etc.; treatment of emergencies, hints on nursing, infection and disinfection, sick room cookery, etc., and although chiefly intended for lay readers, yet it contains much of interest to the professional reader.

THE POPULAR SCIENCE MONTHLY. Published by D. Appleton & Co., New York.

Where all are excellent, it must be supererogatory to make distinction. The January number of the above publication is however so rich, that it is difficult to escape the temptation to award high relative approbation. If we might venture on particular allusion, the article by Dr. Clouston, of Edinburgh, on Female Education, is the one that should command especial attention. It is replete with sound practical sense, as indeed is everything that has come from the pen of that talented and long experienced psychologist.

THE ROLLER BANDAGE, by Wm. B. Hopkins, M.D., Philadelphia, with seventy-three illustrations. Philadelphia: J. B. Lippincott & Co.

The object of this little work is to teach by illustration rather than by elaborate description, the method of applying the roller bandage. Full and explicit directions are given for the application of all varieties of bandages, from the simplest to the most complex. We would especially commend the work to students who are learning the art of bandaging.

ILLUSTRATED MEDICINE AND SURGERY, QUARTERLY, edited by Drs. Geo. H. Fox and Fred. R. Sturgis; vol. ii., No. 3. July, 1883, containing 25 illustrations. Price, \$8 per annum.

We cannot speak too highly of the general appearance and make up of this excellent publication. It is creditable in the highest degree, both to the

editors and publishers, and we trust it is receiving the support it so greatly merits. In the present number there is a beautiful lithographic plate, showing a plastic operation of the face, by Dr. Alfred C. Post, of New York, which is worth the whole year's subscription.

A PRACTICAL TREATISE ON THE MEDICAL AND SURGICAL USES OF ELECTRICITY. By George M. Beard, M.D., and A. D. Rockwell, M.D. Fourth edition. Revised by A. D. Rockwell, M.D. New York: William Wood & Co. 1883.

Having noticed previous editions of this book, it is only necessary to announce the issue of the present one. It contains some slight changes, and the addition of a few pages on static electricity, also the treatment of extra-uterine pregnancy by electricity.

THE OSTEOLOGY AND DEVELOPMENT OF SYNGNATHUS, by Prof. Playfair McMurrich, of the Guelph Agricultural College, Ont.

The above article appeared in recent number of the *Quarterly Journal of Microscopical Science*, Lond., Eng., and is an able and valuable contribution to the morphology of willow-branchiate fishes.

STUDENT'S MANUAL OF DISEASES OF THE NOSE AND THROAT, and their treatment. By J. M. W. Kitchen, M.D., Assistant Surgeon, Metropolitan Throat Hospital. New York: G. P. Putnam's Sons.

A REPORT ON CEREBRO-SPINAL PATHOLOGY. By Daniel Clark, M.D., Medical Superintendent for the Insane, Toronto. Reprinted from the *American Journal of Insanity* for October, 1883.

Births, Marriages and Deaths.

On the 5th of Dec., 1883, W. D. M. Bell, M.D., of Bearbrook, Ont., to Anna Eliza, second daughter of W. P. Lett, Esq., City Clerk, Ottawa.

At Bridgetown, N. S., on the 22nd of December, 1883, S. F. Whitman, M.D., aged 84 years.

At Priceville, Ont., on the 23rd of December, 1883, H. Bennett, M.D., aged 36 years.

In Dublin, Ireland, on the 23rd ult., Dr. John Reddy, of Montreal, aged 62 years.

THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

VOL. XVI. TORONTO, MARCH., 1884. No. 7.

Original Communications.

RECORD OF A CASE OF EXTRA-UTERINE PREGNANCY SUCCESSFULLY TREATED BY LAPAROTOMY AND INTESTINAL RESECTION.*

BY ANGUS MACDONALD, M.D., F.R.C.P.E.

Obstetric Physician to the Royal Infirmary, Edinburgh.

Mrs. S., æt. 28, residing at Comiston Mains, admitted into ward xxiii., Royal Infirmary, on 19th May, 1883, complaining of abdominal pain and swelling, œdema of left leg, and great exhaustion. Recommended by Dr. Graham, of Currie.

History of present attack.—Patient ceased to menstruate in October; up to that month she was perfectly regular. Shortly afterwards she felt great pain in the lower part of the abdomen, on two distinct occasions, both of which lasted for a week. She obtained some medicine from her doctor which relieved the pain. In December she was much troubled with vomiting and sickness, beginning in the morning and continuing during the day. This was found to have no relation to the ingestion of food. The vomiting continued until about four weeks ago, when it suddenly ceased, and has not returned. The patient says she distinctly felt foetal movement until a month ago. She is not quite sure when she first noticed it, but is quite positive as to its having been unmistakably present. In February her breasts began to swell, and continued to do so markedly. Milk could be squeezed out of them until a month before admission. Since then the breasts have become small and hard, the nipples however remaining large and prominent. Four weeks ago she was working very hard at home and thinks that she overstrained herself; she then had pains like labour-pains, and noticed that her

abdomen was beginning to swell, and felt a deep-seated pain in the lower part of it, which became so bad that she had to take to her bed. As the swelling increased she had great difficulty and pain in passing water. About a week before admission she noticed a sanguineous discharge from the vagina. A few days previously her left leg became swollen, beginning at the ankle and gradually extending upwards to the hips. Her family and previous history are good.

State on admission.—Patient pale, anxious-looking, and emaciated. The dropsy referred to in the left leg still present. Temperature varying from normal in the morning to 103° - 104° in the evenings.

Genito-urinary system.—*Sexual history.*—Patient began to menstruate at 15 years. The quantity at each period was profuse, and duration seven days. Sometimes slight dysmenorrhœa. She had one child six years ago.

Physical examination.—Abdomen generally distended; resonant all over, except just above the symphysis pubis, and toward the right flank, where it is relatively dull. Left flank is quite clear. Measurement round umbilicus, $33\frac{3}{4}$ inches.

Per Vaginem.—Vagina is short; the uterus is depressed, the vaginal portion being soft and enlarged, like that of a pregnant uterus. There is a tender fulness in the pouch of Douglas. In the right and left fornices, on deep pressure, a rounded mass can be also felt. The sound enters five inches, and communicates a feeling of increased resistance as it passes over the endometrium.

Per Rectum.—A large semi-elastic mass projects into the pouch of Douglas, flattening the rectal wall, and giving rise to great pain when touched.

Alimentary system.—The patient's tongue is red and fiery-looking. The appetite is poor. There has been considerable diarrhœa of late. The breath smells strongly of "newly-mown hay."

Circulatory system.—Palpation and percussion resonant; a soft murmur accompanies the first sound in the mitral area. Pulse rapid, rather compressible, and collapsing readily.

Respiratory system.—Normal.

Urinary system.—Urine reddish-color, slightly acid, specific gravity 1014, and contains a trace of albumen. Strict rest was ordered and milk diet. Symptoms to be met by astringents, opiates, &c., as they should arise.

*Read before the Edinburgh Obstetrical Society, 12th Dec., 1883.

From date of admission till 12th June, a varying amount of pus and blood was seen to pass from the patient's rectum. The abdomen at the latter date is found still distended, though measurement round the umbilicus is somewhat less—32 inches. The uterine tumour is still felt close to the umbilicus. The mass spoken of previously as flattening the anterior wall of the rectum is not so prominent now; it is very irregular in outline and tender to the touch. Within reach of the finger no opening can be felt on its surface. The swelling has disappeared from the left leg. Breath smell now natural.

2nd July.—Abdomen flaccid and much smaller than before; no pain is felt on pressure. In the left groin there is a feeling of increased resistance; the uterus can also be felt above the pubis. Measurement round the umbilicus, 30 inches.

Per vaginam.—The tumour is felt behind and to the right of the uterus; its surface is very irregular, and is found to extend above the brim of the pelvis on the left as well as on the right. Sound enters five inches; surface of the uterus still rough.

Per rectum.—The tumour is felt, especially on the right side, pressing on the surface of the uterus; it is tender and communicates no feeling of softening. On pressing the abdomen over the tumour, to the right of the mesial line, a peculiar crackling or crepitating sound is elicited.

5th September.—General condition of patient much improved, though the pain in abdomen during the last week has increased. Measurement round the umbilicus, 34 inches. The pain in the abdomen is increased with every attempt at motion. Bowels of late have been regular. As the patient had been on our hands since 19th of May, being now nearly five months, and though she had improved so far as her general condition was concerned and no longer showed any septicæmic symptoms, she yet suffered greatly from pain and became threateningly ill when any attempt at sitting up was made, I came to the conclusion that some active means were warranted in being taken, with the view of affording her permanent relief. As against operative measures, we had to consider the fact that at one time undoubtedly a connection existed between the sac of the tumour and the intestinal canal; but as the intestinal symptoms had of late been in abeyance, I resolved to operate.

Accordingly, assisted by Drs. Chapman, Dunlop and Playfair, on the 9th October, 1883, I opened

the abdomen, with antiseptic precautions minus the spray. Drs. Hart and Barbour, along with several other medical friends, were present. The abdomen was opened and the peritoneum reached without difficulty. It was found that the remains of the foetus were attached to the right and posterior aspects of the abdominal wall. What appeared to be an abdominal adhesion of the cyst was torn asunder, and the bones of the skull, laid bare by this means, were removed. When this apparent cyst was drawn forward, it was found to consist of about five or six inches of the small intestine, the walls of which, where they lay in relation to the abdominal walls, were thick, softened, and almost gangrenous. In the cavity in which the bones of the foetus lay there was a considerable amount of fæcal matter. A loop of intestine, which was adherent to the part above mentioned, was carefully separated from the rest, and was found to contain a fæcal fistula also. The whole of the rest of the contents of the cavity in which the foetus lay were now carefully removed, and the cavity sponged out. The portion of the intestine already mentioned, whose wall formed part of the cyst, was now cut out, and the healthy ends of the bowel brought together as completely as possible by a continuous catgut suture, care being taken to approximate the raw edges completely without including the mucous membrane. The stitches were passed very close to one another, and this part of the operation took up a considerable time. The gap in the mesentery was also brought together by continuous sutures. During this part of the operation there was some hemorrhage, which was, however, completely arrested by the pressure of the sutures. The edges of the fæcal fistula above referred to having been thoroughly rawed, were carefully brought together by catgut suture. The abdomen was now sponged dry, and the wound closed, a large India-rubber drainage-tube being introduced at the lower angle of the wound, so as to extend to the bottom of the cyst, and secured in position by passing one of the deep sutures through its texture. The temperature after the operation was 97.6°, pulse 82. In the evening the temperature was 101.4°, pulse 120 and very thready. During the night the bowels were moved four times, the evacuations being blood and mucus. Great thirst was experienced and slight sickness; slept little. Patient was kept under the influence of opium.

10th October (second day).—Temperature 99°, pulse 126-32, quick and thready. The discharge from the wound was of a dark greenish-brown colour, thick and putrid. The patient has a bad cough, which causes her much discomfort. A mustard and linseed poultice (with a piece of flannel between the poultice and the skin, to keep in the heat and to prevent blistering) was applied to her chest, which gave great relief. The thirst is still very bad, but water was given in teaspoonfuls now and then, with occasionally a small piece of ice; the ice, however, produced emesis. Towards evening the patient became exhausted. Brandy and champagne were given, a teaspoonful of brandy to a tablespoonful of champagne, every half hour. Bowels moved quite naturally. She slept a little during the day. At 11 p.m. the temperature went up to 102.2°, pulse 130. During the night the patient was able to pass urine, it having been previously drawn off. She was very restless, and so morphia was given, and she slept a few hours.

11th October (third day).—Temperature 98°, pulse 120. Stimulants were given as usual, and peptonized meat suppositories were introduced, at first every hour, and then every two hours. Sickness was caused by the brandy, so champagne was given alone. After a time that also was rejected and brandy was again given, and no sickness followed. The discharge from the wound was now found to be mixed with fæces, accordingly the dressing was changed from protective and salicylic wool to marine lint and oakum, which was changed every four hours, the bowels still acting.

From 12th October to 22nd October (fourteenth day).—Patient continued gradually to improve under the same treatment, sleeping slightly better and looking brighter. On the 22nd October the drainage tube was taken out. A charcoal and linseed poultice was used to remove the crust formed by the salicylic cream which I should have mentioned as having been put on. Since the tube was removed no fæces came by the wound. The removal of the crust just referred to, left a large skin-denuded surface on either side of the wound.

25th October (seventeenth day).—One-half of the abdominal surface was painted with liquefied gelatine, and a coating of melted paraffin. The side that was not painted bled very much. The patient slept better during the night. Bowels moved very often, and the evacuations were very offensive.

27th October (nineteenth day).—The patient complains of a fainting sensation and great soreness all over the abdomen, but on the whole feels pretty well. The gelatine came away in a cake owing to the continued discharge from the wound, the part which had been painted looking better than that which had not. The next day gelatine was placed on both sides of the wound, and was found to adhere better than at the last occasion. Patient now takes large quantities of milk and occasionally beef-tea.

This treatment gradually improved the local irritation very markedly and rapidly. The incision which at one time threatened, began to heal kindly throughout its entire extent, and by the end of November the irritated surface was perfectly healed. Latterly an application of boracic acid in glycerine was employed.

12th December, 1883.—At the present time the abdominal surface is completely free from rawness—the wound is entirely healed. There is neither abnormal distension nor abnormal dulness in any part of the abdomen. The abdomen, when percussed over the seat of the foetal sac, gives a perfectly resonant note. The bowels have gradually improved in their action from six times a day to thrice daily, twice daily, and for the last six days once a day only. The patient is putting on flesh and is getting up daily. She walks easily and feels gaining strength daily. I examined her per vaginam this afternoon, and I find now that all pelvic thickening is completely gone. The uterus is natural in size and quite moveable, and not a trace of any deposit or of tenderness can be felt per vaginam. Indeed, the patient gives now every promise of complete restoration to health.

The patient left the Infirmary on the 9th of January, 1884, in good health, with the exception of one day when castor oil was administered, on which there were three stools, the bowels have regularly moved once and only once daily since the 6th of December, 1883. The patient has gained rapidly in flesh and strength, and has been living on ordinary food including meat and fowl.

This would appear to have been a case of abdominal pregnancy which had settled in the right posterior part of the abdomen, and in which the child had lived till about the end of the sixth month. About the time the foetus died, inflammation took place in the sac. Considerable peri-

tonitis was produced with apparently thrombosis of the left iliac vein, and consequent dropsy of the left leg. Concomitantly with these there was absorption of the putrid materials contained in the sac, and the production of septicæmic symptoms, as indicated by the character of the breath and the temperature when she came into the hospital. This threatening state of matters was relieved greatly by the bursting of the sac into the bowel, and the subsequent free discharge of foetid pus per anum. Into the grounds of diagnosis in this case it is hardly worth while to enter, as these are only too plain. We had evidence of an enlarged uterus which was empty, and along with that a very complete history of the occurrence of pregnancy with foetal movements and milk secretion. As the foetus had died, we had no scruples in using the uterine sound to confirm our belief that the uterus was empty. Though the diagnosis was easy, yet the sequel has proved that the case of Mrs. S. is extremely interesting. The centre of importance in the case is its treatment. It may be doubted whether I was warranted in attempting to remove the bones of the foetus; and indeed, from my own experience of the alarming nature of the complications found, I would almost feel inclined, in another case to act upon the principle which was aptly put forward by Dr. Hart, when he came to see the patient the day after the operation, viz.: when there is any reason to fear communication between the sac and the intestinal canal, the moral of this case is to let well alone. Whilst I heartily said amen to Dr. Hart at that time, I am of opinion now that something has been added to our knowledge of what can be done by operation on the intestinal canal by the experience of this extraordinary case, and that though the general principle may be true, there is reason to expect not a few exceptions to it. No one present at the operation believed that the woman could live over twenty-four hours, yet to our surprise and delight she is now living and well, and nearly two months have elapsed since the operation. Besides what was I to do? The patient had been as above stated, nearly five months in hospital, and though she had improved very much, yet the slightest attempt at sitting up brought on attacks of pain that threatened to light up afresh all her peritoneal evils. I could not continue keeping the patient much longer in the house, and to send her out seemed consigning her to certain death. I

accordingly reluctantly resolved to operate. From the amount of suffering which the history of this case shows that the patient went through, I should not, I assure you, lightly subject another patient to the same ordeal. But I rather think that if a patient similarly situated were to present herself again in my clinique, I would feel warranted in the light of the experience gained by this operation, to give her a chance for her life by operating. It will be noticed that the foetal sac occupied the posterior and lateral aspects of the abdomen on the right, passing posteriorly behind the ascending colon, and anteriorly being closely connected with a loop of the small intestine, at least six inches long, which freely communicated with the sac, and, indeed, formed part of its wall, as we found it. This intestine was adherent to the abdominal wall; and it was on separating this adhesion by very gentle traction, believing it was the upper wall of the sac of the foetus, so as to get at the bones which I felt through it, that to my horror and dismay I found myself in the cavity of the intestine. It is idle now to discuss the question whether with greater care it would have been possible to avoid this lesion of the bowel. I simply may say I do not think so, if the operation was to be carried out at all. Having found myself in the unlucky predicament of having to deal with an opening involving six inches or so of intestinal canal, the walls of which were ragged, thickened, softened and almost gangrenous, with, in addition to that, a considerable fæcal fistula of another loop of small intestine, I did my best for the patient by cutting out the unhealthy torn piece and bringing together the raw healthy surfaces as accurately as possible, whilst at the same time I rawed the edges of the small fistula and brought them thoroughly together. This left a gap in the mesentery, which had also to be sewed up. As no operation of this sort was expected, we had made no special preparations for it and were only provided with good catgut. I acted chiefly upon Sir Spencer Well's experience, who, finding he had made a considerable cut into the colon in one of his operations, states that he brought the opposing surfaces together with a continuous catgut suture. This I did to the very best of my ability, taking care to bring out the needle on the one side and enter it on the other exactly at the edge of the mucous membrane, so as to avoid including any portion of the latter in the grip of the suture.

The stitches were also put very close together. The sequel shows that perfect coaptation must have been secured. I really do not know whence the small quantity of fæces came which was on several occasions observed previously to the removal of the drainage-tube. I am inclined to believe that it may have been from some fæces not reached by the sponge in our attempts at emptying the sac, or from a third sinus which had been unobserved, and which had been situated in the large intestine, as the quality of what was discharged was different from the milky-looking chyle which one sees in a case of a fistula of the small bowel. If so, the opening must have been small and must have spontaneously closed up as the other parts healed. Much advantage was derived, in the healing of the irritated surface, by the gelatine and paraffin dressing, which was suggested and carried out by Dr. Cockburn, to whom I owe thanks for his kindness in this connection. The distress from the raw abdominal surface caused by the stinking discharge was truly awful for some time. I have stated that this case appears to me in some points unique, and I still think so. This extraordinarily perfect recovery after resecting six or seven inches of bowel is very encouraging indeed, and ought to make us less frightened if in case of accident during abdominal operations, the intestines should unfortunately be injured.

Of course, resection of the upper end of the intestinal canal for cancer of the pylorus and stomach, etc., has been practised with more or less success by Billroth and other surgeons. But the cases that I have met with which came nearest to mine are two recorded by Professor Edward von Wahl, of the Dorpat Hospital in the *St. Petersburger Medicinische Wochenschrift*, and referred to in the *British Medical Journal* for May, 1883, p. 1015. These were, a case of resection in which two and a half inches of intestine were removed and the opposing ends brought together with a single row of catgut sutures, in order to cure an artificial anus. In this case the patient died on the third day from peritonitis, in consequence of two suture becoming loose. The part removed proved to be a portion of the transverse colon. The other case was one in which Professor Wahl, finding intimate adhesions between a dermoid cyst and the ascending colon, preferred to remove the portion of colon rather than separate it from the tumour. The

reason assigned is that the tumour was already, especially along the line of adhesion, undergoing malignant degeneration. In this case a double row of sutures were employed, one set embracing the mucous membrane and the muscular wall, and the other bringing the serous membranes into contact. This case did well for a month, and then went to the bad, apparently from malignant disease. It is clear in this case however, that the union of the bowel surfaces had been complete, a result which appears to me to have been essentially due to the increased number of stitches. But I will not weary you with any further remarks on this case. After the fact, I have several things to regret—1st. That I did not examine the exact state of the uterus and ovaries. 2nd. That I did not retain the excised portion of bowel. But this cannot now be helped and must be endured.

[For the above very interesting article we are indebted to Dr. H. Aubrey Husband, of Edinburgh.]—ED. LANCET.

CANCER OF THE RECTUM—OPERATION.

BY R. A. CORBETT M.D., PORT HOPE, ONT.

Mrs. H—aged forty-four years; resides in the Township of Hope; farmer's wife; mother of two children; always healthy up to present illness; family history good; no hereditary taint. First consulted me on February 5th 1883. Had been complaining since summer previous. Did not look unhealthy; was fairly nourished, but had become thinner lately.

Symptoms: a gnawing pain in the arms; aching pains across lower part of back, and shooting down right hip resembling sciatica; bowels irregular, but generally costive; passed blood occasionally; supposed she had bleeding piles. On examination I found an irregular tumor situated on the posterior part of the rectum, extending up about four inches, and the size of a goose egg. I decided to remove it, and on February the 19th, assisted by Dr. J. Might of Port Hope, the patient under the influence of chloroform, I removed the growth. It was easily broken up and looked like encephaloid cancer; there was not much hemorrhage. The wound healed rapidly; all pain ceased; her appetite increased, and she went home on the 22nd of March, very much improved in appearance. She

continued in fair health attending to her household duties until the latter part of July, when she returned to me, complaining of a little pain. On examination I found a small hard tumor just within the sphincter. The sphincter was rigid and unyielding and there was an enlarged gland in the right groin. I saw her again during the month of August and found the disease advancing rapidly, enlarged glands in both groins, pain across the back and down the right hips. I advised extirpation of the rectum. Before consenting she went to Toronto and consulted two surgeons. They declared the disease to be cancer, but objected to an operation, and told her to wash the parts with fluid extract of witch hazel, and further that there was nothing but to endure and die. On September 8th Dr. J. A. Mullin, of Hamilton, saw her in consultation, and agreed that her disease was without doubt cancer. During the months of September and October the pain in the right sciatic nerve had become excruciating and unremitting, the function of the parts increasing the suffering; no sleep obtained unless under the influence of narcotics. November 5th; the tumor had increased in size very much, involving the whole of the lower part of the bowel and extending upwards three inches. The sphincter was indurated, rigid, and unyielding; several small tumors had formed outside around the anus. She was tortured with pain, and urgently pleaded for an operation, saying she preferred death rather than endure such suffering. On November 15th, assisted by Dr. A. Hamilton, of Port Hope, the patient being under the influence of chloroform, I excised the whole circumference of the rectum, dissected the bowel up without difficulty for six inches, drew the gut down, and removed nearly four inches. I then attached the stump of the rectum to the skin, with six silver wire sutures. There was no hemorrhage of any consequence, and no vessels to tie. The wound healed in one week, except a little pocket between the bowel and vagina; removed all the sutures on the fifth day. The patient made a rapid recovery, and went home on the 18th of December. Before leaving she had fair control of the bowel, had gained in flesh and improved in appearance. The pain had entirely ceased, and she expressed herself as very much pleased with the result of the operation. February 7th, 1884; I had the opportunity of examining this patient, and found the rectum free from disease; the

glands in the groin about the same size; no pain. The patient sleeps well, feels strong and has gained very much in flesh; has fair control of bowel. There is one thing certain about this case and that is, if the operation does not prolong life, it has been the means of giving the patient great relief from her sufferings. I shall watch the result of this case with some interest.

THE TREATMENT OF ULCERS.

BY A. C. ANGUS, M.D., OXFORD, N. S.

To describe ulcers in all of their details, as to etiology, nosology, pathology, etc., would be to write a book, hence in this article I wish to confine myself solely to the treatment of ulcers.

Ulcers in years past (especially chronic ulcers) have been the opprobrium medicorum. In every community are to be found persons suffering from ulcers. In many cases these have been treated by various kinds of ointments, and finally after months and years of fruitless effort to cure them, the patient's have been told not to heal them for "as sure as you do, it will go to your lungs." I find it to be a popular notion that the cure of ulcers is detrimental to the health. As a result of these erroneous impressions there are persons who suffer from chronic ulcers for years, and even a lifetime without attempting to obtain relief. In standard works on surgery, ulcers are divided into various classes; but as all ulcers are merely so many forms of inflammation with solution of continuity of the soft parts, and with formation and destruction of normal elements, the most rational classification, it seems to me, that can be adopted is into *acute* and *chronic ulcers*. In order to give my method of treatment I shall describe one or two typical cases which I have met with in practice.

Case I.—Wm. B., aged 32, printer and mechanic. Saw him first on the 27th of August 1883. Upon enquiry I found the family history good. The ulcer was situated just above the ankle-joint. When first seen by me it presented the following appearance; ulcer extended half way around the leg; deep ragged edges; the surface covered with a quantity of pus; leg considerably swollen; edges of the ulcer extremely hard. As the patient was anæmic I ordered a mixture of iron and quinine followed by cod liver oil and

Fowler's solution. Locally I applied a poultice for twenty-four hours, then a solution of carbolic acid (1 to 35) to be used with an atomizer, the spray to be blown strongly under the edges of the ulcer, and all over its surface until thoroughly cleansed. No sponge or cloth should be used to cleanse the surface of an ulcer. The leg being very much swollen I applied tincture of iodine very freely until it was reduced to its natural size; also painted the surface of the ulcer a number of times with tincture of iodine which satisfactorily diminished the discharge. Subsequently I used a cloth oiled with vaseline and carbolic acid. The leg was kept perfectly at rest, elevated, and equable pressure maintained by means of a well-fitting elastic stocking. In one month the ulcer was entirely healed.

Case II.—Wm. A., aged 51, mechanic and farmer. Family history good. He had two chronic ulcers 5 by 3 inches, situated one on the outer, and the other on the inner side of the leg, lower third. Ulcers deep; edges callous and ragged; surface partly covered with pale unhealthy granulations, exuding a thin sanious pus. The leg was greatly swollen, and had a dark mottled appearance. The internal treatment was the same as in Case I. Also the same treatment locally with the exception of the use of iodoform ointment instead of tincture of iodine. One of the ulcers did not heal kindly. It progressed favorably for a time and then came to a stand still. I cauterized with solid nitrate of silver and applied a poultice for 24 hours after which I used iodoform ointment and then resumed former treatment. In less than six months from the commencement of treatment the ulcers were healed. The points which I wish to insist upon in the treatment of ulcers especially chronic, are these. 1.—Rest to the affected part. 2.—The use of the atomizer with an antiseptic solution to stimulate and cleanse, thus avoiding the breaking down of the weak granulations in dressing. 3.—The occasional use of strong stimulants to the surface of the ulcer. 4.—When practicable the use of well regulated pressure with elastic bandages. 5.—Such internal treatment as may be indicated. 6.—To quote from Westminster Shorter Catechism, "Perseverance therein to the end."

Selected Articles.

REMITTENT FEVER COMPLICATED WITH HÆMATURIA AND TYPHOID SYMPTOMS.

CLINIC BY PROF. TYSON, PHILADELPHIA.

Gentlemen,—In the case that I shall bring before you to-day there are some rather unusual features, which require study. The history is as follows: The patient, a labourer, 28 years of age, and a native of Ireland, was admitted to the hospital October 11th, 1883. He says that he has been temperate, and denies all venereal history. He was well up to the summer of last year, at which time he was working in New Jersey, and had malarial fever. This continued for two months. In September last he again had chills and fever. On the 1st of October he was exposed to the rain, and this exposure was followed by diarrhoea and a feeling of exhaustion. When admitted into the wards, the diarrhoea was slight, but he passed large quantities of dark-colored urine.

It is evident from this history that the man has had malarial fever; but the symptoms which he presented on admission were also of a kind to suggest typhoid fever. But, after watching the temperature and other features of the case for a few days, it became evident that this diagnosis could not hold. I wish to-day to call attention to the points in this case and discuss them with you, and draw such conclusions as may appear justified.

In the early part of the attack the patient had diarrhoea. When I first saw him, he had a dry, coated, leathery tongue. These, with a more or less constant feverish condition, are the suggestive symptoms alluded to; but careful examination of the abdomen failed to reveal the presence of the characteristic spots of typhoid fever. Even if this eruption, which usually appears about the eighth day, be not present, the temperature record will in ordinary cases enable the diagnosis to be made. The course of the temperature in typhoid fever is as follows: there is always an evening rise and a morning fall; but, as the temperature is recorded day after day, it is observed that the evening temperature is always a little higher than that of the previous evening, and each morning temperature a little higher than that of the previous morning: so that we have a tidal rise in the temperature, which, in the course of the second week, reaches its maximum. As the diagnosis in this case was not positive, the temperature was carefully taken twice a day. October 12th, a.m., it was 100.4°; p.m., 103.2°; 13th, a.m., 98.6°. This was altogether unexpected. Instead of being higher than the previous morning, it was two de-

gress lower. On the evening of the 13th the temperature was 100.6° , higher than the morning temperature, but still considerably less than the previous evening; 14th, a.m., 100.0° ; p.m. 100.4° ; 15th, a.m., 99° ; p.m., 100.6° ; 16th, a.m., 98.4° ; p.m., 98.2° ; 17th, a.m., 98.4° ; p.m., 100.4° . It is not necessary to go further with the reading of the temperature. It is at least evident that there is nothing of the nature of a tidal rise. On the other hand, there is quite a constant morning temperature, which by evening has gone up to about 100° . It is clear that this is not a case of typhoid fever. There is another symptom in this case which does not belong to typhoid fever: there is more or less constant bloody urine. I can account for this condition on no other ground than that it is malarial in its origin. There is no undue frequency of micturition, and no evidence of disease of the bladder or of the kidneys.

The only conclusion to which I could come, in view of these facts, was that our patient's disease was essentially malarial fever of the remittent type, with typhoid symptoms, and might be called typho-malarial fever.

Now, there are two ways in which this term may be applied. In the first place, that disease may be called typho-malarial fever in which there is malarial fever complicated with typhoid symptoms, or the term may be applied to cases in which the two diseases exist together,—that is, typhoid fever running *pari passu* with malarial fever. A third application of the term typho-malarial fever has been made; that is to indicate a special form of fever with its own morbid anatomy, distinct from that of typhoid fever and of malarial fever. But this idea, which originated with Dr. Woodward, of the army, has been given up. Can we in this particular instance settle this question? Can we say whether it is a case of malarial fever with a typhoid complication, or whether it is a case in which typhoid and malarial fevers are concurrent? In the first place, there can be no doubt that two general diseases may coexist in the same individual. You have probably all heard of measles and scarlet fever running their course together. Some diseases are nearly always associated, as, for instance, pneumonia and pleurisy, and pneumonia and bronchitis; but I am now referring more particularly to general diseases.

There is, therefore, no reason why we should not have malarial fever and typhoid fever concurrent. But let us discuss somewhat further the grounds on which we conclude that such is not the case in the present instance. This patient has been under observation for twenty-one days. As a rule, a case of typhoid fever either becomes decidedly convalescent or else ends fatally by the end of the third week. In the course of the third week the temperature begins to fall, and there is a tidal decline. The morning temperature is a little

lower than that of the previous morning; the evening temperature a little higher than the temperature of the morning of the same day, but a little lower than that of the previous evening. If this were a case of typhoid fever, we should expect it to show some disposition to terminate. In point of fact, during the past week the symptoms have become aggravated. His dry tongue had, under the use of turpentine, become moist, and all the symptoms, excepting the hæmaturia, had improved; but last week they became aggravated, and the temperature rose decidedly. On October 24th and 25th the temperature was normal. On the 26th it began to rise, and reached 103° . The next day it was in the morning 103° , and in the evening 104° . Since then the temperature has not been below 100° until the evening of October 31st, when it was 98.4° .

These symptoms, however, suggest a relapse in typhoid fever. You are aware that relapses in this disease are not infrequent; but when typhoid fever relapses it repeats its previous history. The spots, diarrhoea, and peculiar temperature recur. But there has been no diarrhoea; there are no spots on the abdomen; there is no tympanitis; neither is there marked abdominal tenderness. This case does not give us a repetition of the symptoms of typhoid fever, and we cannot consider it a relapse. I feel constrained to class this as malarial fever of the remittent type; for, as you see, there is more or less continuous fever. There are also typhoid symptoms, so that in one sense of the term it is a case of typho-malarial fever; but it is not a case of concurrent typhoid and malarial fever.

As we were under the impression, when he was first admitted, that we had a case of typhoid fever to deal with, he was placed upon a treatment which would really answer for both diseases. In the first place, I always begin the treatment with quinine for a few days, for it is often impossible to tell at first whether a fever is malarial or typhoid. Sixteen grains of quinine per day, continued for four or five days, will have the effect, in the first place, of keeping up the powers of resistance of the patient, and, in the second place, will remove any malarial element. We used quinine in the present case, and the symptoms were much improved. On account of the condition of the tongue, I also ordered ten drops of turpentine four times in the twenty-four hours. We made no local application, as is our custom in typhoid fever, in the form of poultices and turpentine stupes. Under this treatment he improved decidedly. Last week we suspended the treatment, and in the result of this suspension of treatment we have another evidence of the malarial nature of the disease. As soon as the treatment was stopped, all the old symptoms returned. We again returned to quinine and turpentine; but during the past twenty-four hours the administration of these remedies has been interfered with by "hiccough."

The treatment of this symptom has therefore claimed our attention exclusively during this period. Sometimes it is a mere nervous symptom, which a more powerful nervous impression will cause to disappear. At other times it becomes a severe and obstinate complication. You all perhaps recall the treatment for the hiccough of our childhood,—that is, the taking of three swallows of water without interruption, which is the substitution of one nervous impression for another. Hiccough is a spasmodic contraction of the diaphragm, with a sudden closure of the larynx. A variety of remedies have been recommended: one of the best is counter-irritation in the region of the diaphragm. A large mustard plaster will often answer the purpose. If counter irritation fails, morphia, in doses of one-quarter of a grain three or four times a day, may be employed. Failing in this, chloroform, in the form of the spirit or tincture, may be employed in doses of half a teaspoonful every three or four hours. Hoffman's anodyne is sometimes employed with advantage. Nitrite of amyl is also given with satisfactory results. In administering this remedy, the little glass pearls should always be used, one of them being crushed in a handkerchief and the drug inhaled. Another remedy which has considerable reputation in hiccough is musk. As it is doubtful whether we can now procure pure musk, it is not administered as often as it formerly was. Chloral in combination with bromide of potassium is an excellent remedy. The order in which, under ordinary circumstances, I would use these remedies is the following: counter-irritation with mustard, chloral, opium, chloroform, Hoeffman's anodyne, musk, and finally a blister, as we have done in this case. The hiccough has been somewhat improved since the application of the blister. It is intermittent, lasting for a few hours, and then disappearing for several.

During the last few days there has been gradual improvement. The fever has diminished, and the amount of blood in the urine has lessened. This is a specimen of the urine last passed. From its appearance, only, it would be impossible to say whether or not it contains blood. A small quantity of blood in an acid urine gives the liquid a smoky hue, of which this is a fair representation. Sometimes the urine is perfectly clear. This is characteristic of malarial hæmaturia.

We have come to the conclusion that this is a case of remittent malarial fever with typhoid symptoms. As to the cause of these symptoms, it is difficult to say. He may be the subject of septic conditions resulting from his residence, habits, or other causes. Typhoid fever is a form of septic fever, resulting from the absorption into the blood of putrid poisons; but there may be other forms of manifestation of septic fever than the symptoms of typhoid fever. This man may have introduced

into his system septic matters giving rise to the symptoms which he has presented.—*Med. Times.*

SPONDYLITIS. CLINIC BY DR. SAYRE.

Gentlemen: This little child that I now present to you is suffering from spondylitis in the earliest stage.

The parents and other members of the family are perfectly healthy; and this child, beyond the difficulty of the spine, presents a remarkably robust appearance. I am informed that she commenced to complain of pain in her back and side, and of considerable difficulty in breathing, some six months ago, becoming restless, nervous, and irritable. Previous to this she had injured herself in falling from a chair. You will notice that there is a projection of the spine at the eleventh dorsal vertebra, and as she stoops down to pick anything up from the floor, she avoids bending the spine, but flexes the legs upon the thighs and the thighs upon the abdomen, thus squatting down and maintaining the spine in the erect position.

Now, as I lay the child upon her abdomen across my knees, the thighs and arms hanging down on either side, as you see, I slowly separate my knees, and in this manner make gradual traction, by this means extending the spinal column, and relieving the diseased surfaces of the vertebræ from pressure, and thus free the child from pain, and you observe the instantaneous change in her manner of breathing, from the short, quick, jerky respiration, to a deep, full, long inspiration, and the child seems perfectly comfortable. Now by drawing my legs closer together, you notice the immediate return of the previous spasmodic breathing; and now placing one of my hands upon her head, and the other upon her buttocks, and pressing the vertebral column together, she immediately begins to cry with the pain produced, and there is at the same time an instantaneous spasm produced in her legs. Now by gently separating my knees again, and extending the spine, the sobbing ceases, and she states that she is quite comfortable again. You now observe that I am making firm pressure over the spinous processes at the seat of the disease, and, according to all authorities, this should increase the pain; whereas, as you can plainly see, it does not do so. But, on the contrary, when slight extension is made upon the column, and direct pressure with your finger over the projecting spinous processes, there is rather a tendency to relieve the pain, by opening the angle of pressure in front of the vertebræ.

I have found that in these cases of antero-posterior curvature of the spine, by placing the child in this position, and gently pressing downward, at the same time making your traction as I have just described, you relieve the patient. The explanation,

to my mind, is simple enough, viz: by these two manipulations (the disease being situated in the anterior portion of the vertebræ), you relieve the inflamed surfaces from pressure, and, as it were, separate the anterior edges of the vertebræ from each other. This latter, of course, is an impossibility, but at the same time sufficient force is brought to bear by your combined manipulations *to relieve the diseased surfaces from pressure*, and hence the cessation of pain.

This examination we have now made will reveal the disease if it be in the anterior part of the bodies of the vertebræ; but there may be some cases in which the examination we have just made will reveal no evidences of disease at all, and at the same time there may be spondylitis existing. But by a more careful examination you will find the disease upon the side of the bodies of the vertebræ, and it has been caused by some blow or pressure upon the ribs, driving the heads of the ribs into their facets. You detect the disease in this position by pressing upon each rib separately, and the moment you come to the point of disease the patient will flinch with the pain induced by your pressure.

Having now made our diagnosis, I call your attention to the treatment of the case. I shall here apply the plaster-of-Paris jacket and *jury mast*: and will now show you the method of its application.

The child has already been thoroughly cleansed, and we put upon her a skin-fitting knitted wollen shirt tied over the shoulders, manufactured expressly for this purpose by the Bickford Knitting Co., 841 Broadway, this city. We now fold two towels and pass under the shirt in front, allowing them to extend the full length of the trunk. This is to prevent pressure upon the viscera, and allow of free respiration and expansion of the abdominal walls after eating; these towels being withdrawn as soon as the plaster has become sufficiently set. Having now adjusted the towels, the shirt is drawn down tightly and secured between the legs with a safety pin, and your patient is then ready for a partial suspension necessary during the application of the plaster-of-Paris jacket.

The child we now place in the suspending apparatus, which you will notice consists of an iron cross-bar with a chin collar of soft leather, and arm supports also. Having carefully adjusted this so that the weight of the body is borne evenly upon the arm-pieces under the axillæ and the chin collar which supports the head, we make gradual traction upon the vertebral column until our patient states that she is perfectly easy and free from all pain. In this case you will notice the traction necessary to secure this result, is sufficient to slightly raise the heels from the floor; in some cases this is not necessary, and again in others the traction required may be still greater; but never under any circum-

stances should your traction be so great as to lift your patient *completely from the ground*. This I desire you to specially understand, otherwise the word *suspension*, used in our description of the treatment, may lead you to suppose that the patient is to be literally suspended, when in reality it is but *partial suspension*.

This child then is fully prepared for the application of the jacket, and I will at once show you the manner in which it should be properly applied. You will here notice that I have from eight to twelve rolls of bandages formed of crinoline, into the meshes of which the dry plaster-of-Paris has been well rubbed and then rolled up moderately loose; not by any means as tightly as the ordinary roller bandage used in surgical dressings, but sufficiently tight to retain the plaster in the fabric, and at the same time allow of it becoming saturated to its centre rapidly when placed on the water. These bandages vary from two and a half to four inches in width, and also being from three to four yards long, depending upon the size of the patient.

I now place a roll of the bandage in a pail of tepid water, which is sufficiently deep to cover the bandage when standing upon its end, and then wait until it has become thoroughly saturated, which is shown by the cessation of the escape of air from the water. I again place another roll in the water, that it may become saturated while I am applying the one previously immersed. This one, as you observe, I now remove, and pressing out all surplus water, I carefully wind it around the waist of the child, my two assistants rubbing each layer of the bandage well into the preceeding one. I would here call your attention to the manner in which I commence the application of the jacket, viz., at the waist, gradually going down until I come to just above the great trochanter. Then carefully reversing the bandages, as you see, I pass upwards again, and having secured sufficient thickness at the waist, I then pass on up the trunk, until I am on a line with the axillæ, and a little higher in front over the chest, and also higher over the scapulæ at the back. In some cases you find it necessary to put padding between the shirt and your plaster bandages, over the sacrum and crests of the ilii, and also *on either side* of the projection of the vertebræ where the disease is located, in order to prevent excoriation of these parts. But never put any padding *upon the projection of the vertebræ*, but place it upon either side, to prevent pressure upon that point. If you fail to do this and allow of pressure to be made there, it may result in a painful ulcer, which will delay your treatment many months; for if such an ulcer should be started the jacket must be at once removed and the patient placed in bed, until such time as it shall have healed, when the jacket may be again applied. I do not wish you to under-estimate the importance of this careful padding. It is not the plaster-of-

Paris that is going to effect a cure of this disease, but your skill in its application, and formation of a jacket by its use which will support and relieve the diseased surfaces from pressure, until such time as all morbid changes have been checked, and a healthy action set up in the hitherto diseased parts.

Now, in this case, although the disease is low down, I shall apply the *jury mast*. In some cases where the disease is so low down, I have omitted the jury mast, as its appearance is oftentimes objectionable. My friend, however, Prof. Samuel W. Gross, suggested that it be used in those cases in which the disease was low down as well as high up in the spinal column, and stated that he had secured much better results in its general application. I must heartily endorse his suggestion, and now apply it in almost every case of spondylitis.

You have observed that I have now shaped the lower portion of the *jury mast* to the back of the child, the lower part of the instrument consisting of these two iron strips which pass upon either side of the spine to the exact contour of the child, and it is now placed in the centre of the body, the bars running upon either side of the spine, the strips of perforated tin which you here see passing from the iron bands two-thirds around the body of the child. My assistant now retaining this firmly in position, the central rod running over the back of the head to the vertex, we again continue the application of the plaster bandages until the lower portion of the instrument is securely embodied in the jacket, my assistants, as you observe, rubbing each layer of the bandage into the preceding one.

You have now seen how simple the method and easy the application of the plaster-of-Paris jacket is. This child should now be laid upon an air bed, but as this is not at hand, we must substitute the ordinary hospital bed, and allow her to remain there until the plaster has become thoroughly set; it is then to be trimmed out under the arms and in front of the thighs, to allow of perfect flexion of the limbs; after which time the leathern collar which I here show you, is placed under the chin and occiput, then by means of these two straps on either side, which pass up, one over the inferior maxilla, and the other from the occiput to this small cross-bar attached to the central rod of the jury mast, our support is secured for the head and by means of which the entire weight of the head is removed from the spinal column if the straps of the head-rest be properly adjusted. You must, however, at all times be certain to get your central point of traction or suspension by means of this cross-bar at the end of the jury mast, immediately above the vertex of the head; leaving room at all times for a cap or hat to be worn upon the head under the instrument. At no time must the jury mast press upon the head; the distance desirable between the cross-bar and the top of the head is from three to four inches.

In removing the child from the suspension after the jacket has been applied, you must be extremely cautious that you do not allow her to bend her back before the plaster has set, otherwise your labor will have been lost. Also while applying the jacket, see that you carefully mould the jacket in above the crests of the ilia, so as to secure a shoulder for your jacket, but do not mould it in so severely as to cause pressure or excoriations.—*Medical and Surgical Reporter*.

OBLIQUE CIRCULAR AMPUTATION.

BY JAMES HARDIE, M.D.ED., F.R.C.S., ENG.

The object I have in view in this short communication is to bring under your notice a method of amputating, by which the operation may be rendered as simple and expeditious as appears possible, and the correct principles of guidance be, at the same time, fully observed.

I will take it for granted that these principles include the following: 1. Due regard to the preservation of the length of the limb. 2. Ample cutaneous covering of the bone. 3. The location of the cicatrix out of the line of pressure. 4. Due regard to the nutritive supply of the stump, and the proper coaptation of the cut surfaces.

These conditions are, to some extent, antagonistic. For example: length of limb would be best secured by two equal sized flaps of skin only. But this would place the cicatrix directly under the end of the bone. Again, the nutrition of the stump would be best secured by including a large proportion of muscle, as in the ordinary flap-operation. But this would entail a higher division of the bone than skin-flaps, and difficulty would be experienced in accommodating the fleshy mass. To give all considerations their due weight, it would appear that a long flap of skin, with a quantity of muscle sloping from its base to a little distance from its free border, on one aspect, and a short flap of skin only, on the opposite aspect, would be the best method which could be devised. For obvious reasons, the long flap would generally be on the anterior aspect, and the short on the posterior. This is, practically, the operation Mr. Lister recommended, in his essay in *Holmes's Surgery*, for the thigh and leg. It is, of course, in these situations that full attention to the method of operating is chiefly demanded; and, though the principles are applicable to the upper extremity also, my present remarks have reference especially to the lower.

While fully agreeing, then, with Mr. Lister in the soundness of the principles which he advocates, I have yet constantly found, both in my own practice and that of others, that a certain degree of inconvenience is attached to this method of opera-

ting. In forming the posterior flap, the limb must be elevated considerably, and the surgeon has to cut somewhat awkwardly underneath it. In addition to this, considerable care has to be taken that the flaps bear a certain proportion to each other, in order that they may come together accurately. A certain amount of difficulty thus attends the operation, and it takes a somewhat longer time than one likes. Possibly, in consequence of these disadvantages, it does not appear to find that amount of favour which it otherwise merits; and certainly, judging from the number of stumps, both of the thigh and leg, which one meets with, showing a total disregard for the position of the cicatrix, and therefore for the future comfort of the patient, one would imagine that a ready method, by which the most important detail may be secured, is still a desideratum.

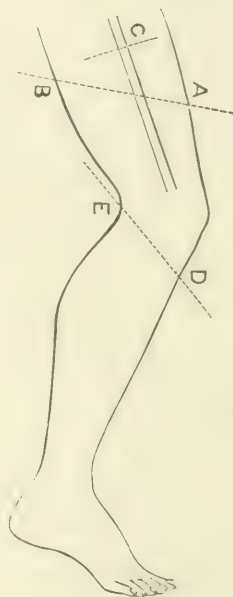
These considerations have led me to introduce into my own practice a different method of carrying out the objects which I have indicated. Bearing in mind the favour which the circular operation generally receives at the hands of operators, on account of the ease and rapidity with which it may be executed, it appeared to me that it might be so modified as to attain these objects in a very complete manner. I have, therefore, been accustomed to hold the knife obliquely to the axis of the limb, in making the sweep around it, instead of transversely, as in the ordinary operation. To take the middle of the thigh as an example, I place the heel of the knife at A, draw it round the limb obliquely, upwards and backwards, at an angle of about 55° to its axis, to B, where the direction changes, as it passes round the posterior aspect, to a direction obliquely downwards and forwards back again to A. Both at A and B, the line of incision is slightly rounded, so that A is convex and B concave. This incision goes at once down to the muscular aponeurosis; although it is convenient for the subsequent insertion of the stitches to have the skin free from fat midway between the upper and lower limits of the incision, on both the outer and inner side of the limb, as the flap has here to be folded on itself. The skin and its attached fat is next dissected back for a couple of inches at A, and taken in hand by an assistant, who pulls it upwards, so as to enable the surgeon similarly to separate it to a less extent all round the limb. This being done, the knife is then sunk obliquely into the anterior muscular mass, as was done by Alanson, until it reaches the bone; and the whole being well retracted, the remaining mass of muscles is totally divided in the ordinary manner by two principal strokes of the knife, the direction of which is still slightly oblique towards B. The bone being cleared, it is sawn at C, which is about an inch or an inch and a half above B.

As a result of this method of operating, the anterior portion of the soft parts falls well over the

face of the stump and end of the bone, the convex anterior flap fitting nicely into the concave posterior, and, when healing is completed, the scar is behind the bone, and in no danger of pressure. All the advantages of the method by long anterior and short posterior flaps are also preserved, and I believe it will be found that greater facility and expedition in operating are secured.

[A patient was exhibited in whom the operation was performed at the junction of the middle and lower thirds two years previously, and who was able to walk perfectly with the weight of his body resting principally on the end of the femur].

Amputation through the knee joint, with preservation of the patella by this method, I find to be a most excellent operation; excellent in the ease with which it is performed, and in the stump



which results. In this situation, owing to the distance to which the integuments of the ham retract after their division, it is advisable to draw the incision less obliquely than in the thigh, and my rule is to begin an inch and a half below the tubercle of the tibia, and to draw the knife round to a point about an inch below the cutaneous fold of the ham, D E. The skin and subcutaneous cellular tissue having been dissected up until the lower border of the patella is visible, an operation which is facilitated by flexing the knee, the ligamentum patellæ is divided, and the head of the tibia, with the semilunar cartilages, then separated by division of the other ligamentous structures. The assistant having then carefully drawn the posterior border of the incision out of harm's way, the whole of the structures behind the joint are next divided by a single stroke of the knife, from the surface inwards. With the exception of Syme's ankle-

joint amputation, I know of no operation which gives a better stump than this amputation through the knee; and I may remark, parenthetically, that I believe we should consult the prospects of recovery, and the future comfort of our patients, were we oftener to select amputation in this situation rather than in the upper third of the leg. [Two patients were exhibited showing this amputation].

In the leg, the incision may be drawn from before backwards and upwards, as in the thigh, special care being taken to slope the knife well upwards when dividing the sural muscles. Occasionally, on account of the tendency which the skin covering the inner surface of the tibia has to slough, I have taken the covering from the outside, retaining as much as possible of the muscular tissue attached to the fibula; and dividing the bones almost at the level of the incision on the inner aspect. The former method gives the better stump should no accident befall it, but the liability to sloughing is undoubted.

Although it is to amputation in the lower limb that I look upon this operation as specially applicable, yet I have also had recourse to it in the upper. Here, probably, the covering is best taken from the posterior aspect; and, in one case of amputation through the elbow-joint, I obtained an exceptionally good result in this manner.

I have practised this operation now for over ten years, under the name "oblique circular" amputation, as a term best describing its main feature. I am bound to confess, however, what I have not long since discovered, that an operation in all essentials the same has for long been described by French writers, as invented by Soupart of Liege. Though I cannot, therefore, introduce it to you as a new operation, yet I can cordially recommend it as an old one. I should have been glad, had I been able, to bring before you a greater number of persons on whom I have practised it; but, although I have only succeeded in tracing three whom I could bring to this meeting, I can frankly state that their stumps are not better than those which may generally be obtained.—*Brit. Med. Journal*.

INTESTINAL OBSTRUCTION.

The innate disposition of human beings to argue, the almost invincible desire of men to differ from one another, was never more clearly demonstrated than in the discussion of the important question of "Intestinal Obstruction" at the recent meeting of the British Medical Association. From the *British Med. Journal*, October 6, 1883, we note that the discussion was opened by Mr. Rush-ton Parker, the essence of whose address was that in all cases of intestinal obstruction, we should avoid all active treatment, and content ourselves

with merely watching the case carefully and noting any symptoms that may aid us to an accurate diagnosis, when our line of treatment becomes plain. The constitutional symptoms of intestinal obstruction are practically identical, no matter what the cause may be, and until some special sign calls our attention to the particular cause, Mr. Parker's expectant plan of treatment is clearly the rational one.

Suppose we have obstruction from invagination, or intussusception; we know that nature cures this condition by a process of gangrene of the incarcerated gut and union of the upper and lower segments of the unimplicated intestine; suppose now, before the union has become firm, or while the process of eating through of the invaginated gut is going on, we administer purgatives or enemata to remove the obstruction—will we not almost necessarily produce perforation, extravasation and death? Hence Mr. Parker's wise injunction: *When in doubt, use opium enough to control the pain, stimulants enough to keep up the strength, and avoid solid food*; if invagination be the trouble, this treatment will put the bowels in "splints," until nature restores the continuity of the canal; if it be not so, then no harm results from our treatment. But, on the other hand, if we can clearly make out the cause of obstruction, without excessive and likely to be injurious manipulation, and if it calls for surgical interference, as in strangulated hernia, adhesive bands binding down the gut, volvulus, carcinoma or some other tumor pressing on the bowel, Mr. Parker advised operation.

Several of the distinguished gentlemen present, catching only Mr. Parker's first part, or expectant plan of treatment, and either wilfully not hearing his wise regulations concerning the indications for operative interference, or actuated by a desire to hear themselves talk, roughly handled Mr. Parker. They assumed that he advised the "let-alone" treatment in all cases, and they censured him severely for it, indicating that operation was imperatively demanded in certain instances, and citing cases to sustain what they claimed, all of which Mr. Parker had already said. His views were probably a little more conservative than those held by some of his critics, for Mr. Lawson Tait held that it was wholly unnecessary and dangerous to wait for an accurate diagnosis, and he advocated early opening of the abdomen in the middle line, with the formation of an artificial anus in the first piece of distended intestine which presented. With all respect for this distinguished opinion we must think that the error of such precipitancy is evident; for should the obstruction prove a naturally curable one, as in many cases it would, we have not only subjected our patient to a dangerous operation, but we have afflicted him with a disgusting and inconvenient deformity. Again, by such a procedure, we are just as likely to open the gut

below as *above* the obstruction, and in such an event we are truly "out of the frying-pan into the fire."

It may be much more brilliant surgery, but it seems more in accord with the dictates of common sense and prudence to postpone surgical interference, either until diagnosis is sure, or until nature has demonstrated that, unaided, she is incapable of correcting the trouble. Billroth has set the example of bold and almost reckless surgery; and in these days of competition and overcrowding, he has plenty of disciples, anxious to gain notoriety by similar boldness; but the teachings of our really great masters, of nature and of experience, clearly indicate that the resort of the knife should be truly a "*dernier ressort*," and that it is always best to give nature a fair show. It is easy enough to *cut*, but it is sometimes extremely difficult to *heal*, and it behooves us to think twice before we cut once. There are certain clearly defined cases of diseased condition, where the knife is the only corrective, and "intestinal obstruction" is not one of them. We will better fulfill our noble mission, if we patiently watch and wait, until nature tells us in unmistakable terms that her opponent is too powerful for her great energies, and indicates clearly that she requires the assistance of the surgeon's knife, which we cheerfully admit in certain cases, such as tumors, constricting bands, and the like, she does.—*Med. and Surg. Reporter. Phila.*

CONGENITAL INGUINAL HERNIA, COMPLICATED WITH UNDESCENDED TESTICLE.

Dr. F. N. Otis related the following case in the New York Medical and Surgical Society (*N. Y. Med. Jour.*): Not long since, a farmer, about thirty-five years old had been sent to him by Dr. Fanning, of Stony Brook, Long Island, complaining of great difficulty in wearing a truss for inguinal hernia. The trouble was found to result from the presence of an undescended testicle. He stated that, from infancy, there had been a slight swelling in the inguinal region. But little was done for it until he was twelve years old, when a physician discovered that it was a hernia, and, reducing it easily, applied a truss. This caused a good deal of pain, and it was then found, on closer examination, that there was only one testicle in the scrotum. The other one was discovered just below the external ring and was movable, but it was not situated low enough, and could not be pushed up high enough to allow of the use of a truss without pain. The hernia was of considerable size.

When the man consulted Dr. Otis, November, 13, 1883, he was considerably reduced and had an expression denoting habitual suffering. He said he had tried various kind of trusses, but they all pro-

duced intolerable pain if worn continuously for more than a few hours. The hernia always protruded to the size of a hen's egg on the slightest departure from the horizontal position but it was readily reduced, the ring being very large. The testicle was found lying on the aponeurosis of the external oblique muscle, between it and the superficial fascia, and movable, from an apparent point of attachment at the border of the external ring, nearly three inches downward—to just within the scrotum, and upward to a point opposite the anterior superior spine of the ilium. It was somewhat atrophied, being about an inch by three quarters of an inch in its diameters, and quite sensitive on pressure. The patient was very desirous of having it removed and the hernial opening closed at the same operation. He had been married several years, and his only child was three years old.

Dr. Otis believed that the testicle was of little use, and that it would be entirely proper and safe to remove it, as it apparently had no direct connection with the peritonæum. He was not so much inclined to operate on the hernia at the same time, however, and he asked that Dr. Markoe be called in consultation. Dr. Markoe agreed with him entirely. Rather more than three weeks ago he removed the testicle. It was pushed up as high as possible, and outward toward the border of the ilium. On cutting through the skin and the superficial fascia, the testicle protruded with its coverings. The cord was readily drawn out to the extent of about two inches and a half, and was secured while excision was performed. The vessels, evidently considerably atrophied, were then tied. There was but little hæmorrhage. The wound was sponged with a solution of bichloride of mercury (1 to 1,000), and a carbolyzed-gauze compress and a spica bandage were applied. The patient had been subject to attacks of vomiting at times, and on such occasions he had been unable to retain the hernia within the abdomen by any means. He vomited a good deal after coming out from the effects of the ether, considerable pain was complained of, and, on removing the bandages, the hernia was found to have descended. It was easily reduced, the compress was replaced, and the patient did well.

PLASTER DRESSING FOR MOVEABLE FRACTURES.

I have read with much interest the concise and instructive article by Prof. Walker, of Detroit, on the use of plaster-of-paris as a dressing for surgical purposes. In a conversation with my friend, Prof. Dawson, of Cincinnati, last summer, he described to me a dressing for fractures occurring at or near the shoulder joint, in which the plaster on strips of muslin of variable lengths, was laid on and over the injured part, strip at a time, making a dressing

absolutely immovable and highly satisfactory in every way. I was called to assist Dr. Judkins, of this place, in dressing a fracture of the humerus, about one inch from the shoulder joint, in a man strong and muscular, æt. 60. The man had fallen from a tree, striking on the palm of the hand, breaking the bone as above, and driving the upper end of the lower fragment forward and upward, tearing the soft parts, and almost coming through the skin below the clavicle. Owing to the severity of the injury, a simple dressing was applied, and evaporating lotions used, after the fracture had been reduced under chloroform. In a week or ten days we put the plaster dressing on, as above described: 1st. Bandaging the arm and shoulder carefully and smoothly. 2nd. Cutting a bandage into short strips, one inch wide, and from four to twelve inches long. Then with the plaster made thin, and to which a small part of potas. sulph. had been added, each piece of the bandage was saturated and carefully laid on over the bandage already on the shoulder. By such means a complete mould was made of the arm and of the scapular and clavicular regions. When the plaster had set, the bandage first put on was cut up on the inner side of the arm and across the shoulder above, and the cast removed. The edges trimmed, the splint was well padded with cotton, re-applied to the shoulder and retained by a roller. I am well pleased with the dressing and the result in this case. The parts were held firmly, quietly and immovably, the dressing was cool, did not cut or bind at any point, a fault so common in all other dressings for fractures in this region. It could be removed and re-applied with ease, and without moving the arm in any degree. In cases of injury at the shoulder it seems to me this form of dressing has marked advantages over any other dressing that can be applied. And for immediate application it would not be open to the objections urged against the plaster dressing applied by the simple roller. But any fracture can be dressed in the same manner, and where there are irregular surfaces, I do not think any other form of plaster will compare with it. One thing should be borne in mind, the strips being laid on one at a time, do not require to be heavily coated with plaster. Unless attention is paid to this the cast will be unpleasantly heavy.—*Med. Age.*

ANTISEPTICS IN GERMANY.—Dr. Lardy, on a visit to Germany, in a letter to the *Union Médicale* (December 27), furnishes some information with respect to the antiseptics now most in vogue in that country. The somewhat exorbitant prices of the Listerian dressings, and the search after a perfect antiseptic have, he says, not a little modified the practice of surgeons of late. The employment of spray is more and more abandoned, and is now

only resorted to for the purpose of disinfecting the theatre before the operation. It is advantageously replaced by the frequent washing of the hands in a disinfecting solution, and by the more or less continuous irrigation of the wound and its vicinity by a 1 or 2 per cent. carbolic solution, solution of corrosive sublimate, etc., etc. The enthusiasm for carbolic acid has much abated, and in many universities its solution is only employed for the disinfecting of instruments, because it does not damage these. For other purposes that excellent disinfectant corrosive sublimate is preferred for its cheapness, and for the rapidity with which very weak solutions destroy the very spores of infecting organisms. The solutions most generally employed are 1 per 1,000 for infected wounds, 2 per 1,000 in ordinary cases, 1 per 5,000 for irrigation during the operation, and 1 per 10,000 in laparotomies, in which the object is direct injection of the peritoneal cavity. The results are excellent. In a certain proportion of cases some absorption of the agent is indicated by a slight elevation of temperature for two or three days at most, but this is very rare. The secretion of the wound is not abundant under the sublimate, and good healing by first intention is obtained. The solution of this disinfectant has also the great advantage of not rendering the skin of the hands so rough as carbolic acid. *Chloride of zinc*, much recommended by Kocher, of Bern, also furnishes good results in a solution of 2 per 1,000, and is especially employed in washing out the peritoneal and pleural cavities, presenting as it does little danger of absorption. It is curious that Koch, of Berlin, should still deny its antiseptic value, for experience shows that he is absolutely wrong. More recently, Prof. Kocher has proposed the *subnitrate of bismuth*, the disinfecting power of which would seem to be more potent than that of iodoform, while it is exempt from the danger of the latter. For the irrigation of wounds a solution of 1 or 2 per 1,000. It may also be employed in powder, or a bismuth gauze of from 10 to 20 per cent. is easily made. Prof. Socin, of Bâle, has recently proposed *oxide of zinc*, which is preferable to bismuth only when more concentrated solutions are required. These two last antiseptics are also employed in the form of a paste, in order to close in hermetic fashion wounds recently sutured, and with bismuth used in this way splendid cicatrization by the first intention may be obtained. Last summer, a mixture of sugar and naphthalin was used at the Strasburg Clinic, and Prof. Lücke, a great admirer of popular remedies, was full of enthusiasm for the new treatment. Iodine-water, thymol, and salicylic acid may be mentioned, although their employment has not become generalised; but, on the other hand, concentrated *tincture of iodine* has attained more favour as an energetic disinfectant in septic wounds, the cavi-

ties of abscesses and mortified and fetid soft parts. Iodoform is employed now more in France than in Germany, where fear of intoxication prevails. It is especially in favour, like naphthalin, for small dressings at the dispensaries. For dressing wounds successive layers of bismuth paste are applied, which are covered by simple gauze that had been previously soaked for some hours or some days in a solution of carbolic acid, sublimate, or bismuth—squeezing out the liquid at the time of application. This gauze costs infinitely less than that of Lister and analogous gauzes, and furnishes quite as good results. The protective and caoutchouc have also fallen into desuetude, and the wadding is replaced by the most various materials. Nearly every clinic has its own procedure, from carbolised jute to turf, moss, sand, ashes, sawdust or powdered glass; marsh-turf, moss and sawdust are washed in abundance of water, dried and roasted at a temperature of from 100° to 100° C., and disinfected in a sublimate solution of 1 or 2 per cent. They are then dried, put into bags, and placed over the dressing in the same way as wadding.—*Med. Times and Gazette.*

A NEW METHOD OF APPLYING PRESSURE TO ENLARGED TESTICLES.—Dr. J. L. Corbett of Lucknow, writes in the *Lancet*: In the treatment of some of the diseases of the testicle, accompanied with enlargement, the practice of applying pressure to the gland is undoubtedly a sound one, and is frequently resorted to by surgeons. I have often wondered that some simpler plan than that of strapping with plaster has not been suggested. The objections against the plaster strapping are numerous. First it is a tedious business to do neatly and properly. Second, it is dirty, both for operator and patient. Third, the operation has to be begun by encircling the neck of the gland with a long strip of plaster. This undoubtedly interferes with the free circulation in the vessels of the cord, and tends to prevent the absorption of the material deposited in the gland. It stands to reason that the freer the circulation in the vessels going to or from the testicle, the more rapid will the reduction in size be from the operation of absorption induced by pressure. Fourth, the strapping loosens very rapidly, and, to be of use, must be reapplied frequently. Fifth, in many cases, even when carefully applied, the plaster cuts the skin and leads to sores. Sixth, I have seen nasty, troublesome eruptions on the skin of the scrotum, following the use of the plaster. I have, I think, enumerated enough objections to the old plan; and I will now try to explain the means I would recommend for obviating these objections, at the same time applying a steady, equable compressing force, and one which would also admit of easy regulation as regards the amount of compression. I may preface the explanation of my plan

by saying that I derived the idea from a homely source—nothing more nor less than seeing the means employed for encasing a football; barring that, instead of having the encasing material made of leather, I would have it made of India-rubber—such as one sees in the construction of the balls in spray-producers, etc. The cases I recommend should be made of different sizes, many thicknesses, oval in shape (same shape as the Rugby football when inflated). The means of tightening the cases and applying the pressure would be identically the same as the football cover—*i. e.*, by lacing. There should be an opening at the neck of the case to allow the passage of the cord. This opening would be surrounded by a ring (interrupted) of leaden wire to insure its patency and to prevent pressure on the structures of the cord. The leaden wire ring being interrupted, its softness would offer no obstacle to its adjustment round the neck of the enlarged gland. With a supply of the cases which I have attempted to describe above, the treatment of an enlarged testicle would offer but little difficulty: it would simply mean the selection of a rubber case of the right size and thickness, and capable, when laced up, of exercising a steady, equable pressure on the enlarged organ, and applying the case to the testicle and lacing it up. If considered necessary, the testicle could first be enveloped in a thin layer of cotton-wool: this would prevent any possibility of the skin being nipped or chafed by the lacing. As the gland reduces in size, a smaller case would be applied, and thus a steady pressure kept up until a cure was effected. The above plan has the advantage of simplicity, neatness, and quickness in its application, to recommend it. It involves no elaborate apparatus, and I think does away with many, if not all, of the objections connected with the operation of strapping with the plaster.—*N. Y. Med. Jour.*

PAROVARIAN CYSTS.—Dr. Goodell exhibited two cysts of the parovarium before the Obstetrical Society of Philadelphia (*Medical and Surgical Reporter*, January 5th). Both patients got well; he indeed had never lost a patient from whom he had removed a parovarian cyst. In both cases a correct diagnosis was made previous to the operation. Regarding the differences between this tumor and the cyst of the ovary, he remarked that one interesting diagnostic point was the complete absence of the *facies ovariana*. The color in the cheeks was good, and the countenance was free from the anxious expression present in cases of ovarian tumor. One tumor had existed for ten years, the other for one. Another important point in the differential diagnosis is not only the flaccidity of the tumor but its variable degrees of flaccidity. Upon inspection, it is seen to reach to the sternum, and seems to occupy a large portion of

the abdominal cavity, but when the hands are placed upon its sternal edge it can be compressed to the level of the umbilicus. An ovarian cyst, on the contrary, is hard and uncompressible. Exceptions to this rule are very rare, that is, either a tense parovarian cyst or a flaccid ovarian one. A third important distinguishing point is the long time—ten years in one case—which the tumor existed, and further, without marked deterioration of health. After being tapped these tumors usually refill, but occasionally they do not, and a cure is thus brought about. The fluid withdrawn has been in every case limpid and generally colorless, but it has sometimes had in his experience an emerald tint. These tumors are generally free from serious adhesions, but if, in an operation for the removal of one, adhesions should exist where for any reason their forcible separation would be unadvisable, or the cyst were intra-ligamentous, he would not hesitate to leave the adherent portion of the cyst wall, or the whole cyst itself, after making a big hole in it, as the fluid it secretes is bland and unirritating to the peritonæum.

Any one examining one of these cysts for the first time would consider it to be of ovarian origin, for it is only by patient search that the ovary can be found spread out over the cyst wall. The microscope will decide with certainty in any otherwise doubtful case. The tumor is covered with a beautiful net-work of veins.

When a cyst of the parovarium exists on one side, the ovary of the opposite side is usually found to be diseased and should be removed. In these cases the remaining ovary was seen to be enlarged, and the site of a small ruptured cyst was pointed out. The Fallopian tube was also enlarged, and the terminal vesicle of the Fallopian tube, or the hydatid of Morgagni, was enlarged and cystic. This hydatid sometimes attains the size of an orange, and often ruptures spontaneously without any bad effects. A few years ago one of these small cysts ruptured while he was making an examination of the patient to ascertain its character.

A RENAL FORM OF TYPHOID FEVER.—Dr. Didion has chosen this subject for an inaugural dissertation, and comes to the following conclusions: Typhoid fever produces a renal congestion, which plays an important part in the course of the disease. Albuminuria is almost constant, but generally slight and temporary; when abundant, it is a sign of true nephritis. The real inflammation is both parenchymatous and interstitial, and produces certain characteristic symptoms, such as asthma, stupor, dryness of tongue, œdema of the face and legs, lumbar pains, cutaneous eruptions (pemphigus, ecthyma, boils), and an alteration of the urine, which has a reddish color and the odor of boiled bread: to the deposit, red and white blood-corpuscles are found, as well as casts; the

urine contains a large quantity of albumen. The diagnosis can easily be arrived at by the above-mentioned symptoms. The termination is often fatal, either from asthenia or uræmia. As to the treatment. Bouchard recommends carbolic acid and the salicylates, Polli the sulphites, Klebs the benzoate of potash. Leeches, mustard poultices, and cupping in the lumbar region are useful; but blisters even with the addition of camphor, must be avoided. In certain cases the disappearance of the symptoms is accompanied by abundant diuresis, which ought therefore, to be favored if possible; but all diuretics are not equally good, those which possess irritating properties must be avoided. The best in these cases is milk, pure or mixed with water. Whatever may be the way in which it acts on the kidneys, it is always well borne and its action is double; it increases the secretion of urine, and hastens the elimination of toxic principles, without producing any irritation, even in the most acutely inflamed kidney. Subcutaneous injection of pilocarpine might perhaps be useful; in one case when the skin was dry and burning hot, Dr. Didion injected twice daily one-sixth of a grain of pilocarpine, and under its influence the skin became moist and abundant sweat was produced; the tongue also was less dry than before; the temperature fell in two days from 105.8° to 98.6° F.; but three days later the patient died, after the temperature had once again reached 104° F. New investigations are necessary before we can arrive at definite conclusions. As for the cold baths, Gubler thinks that they are contra-indicated in case of nephritis, but Libermann considers their use as surely beneficial in spite of it. Several patients who had been subjected to that treatment did not complain of any inconvenience, and cold lotions rapidly applied to the trunk and limbs with a sponge seemed to relieve the patient, lower the temperature, and re-establish the functions of the skin. All these advantages must be weighed against the danger of a renal congestion; but further experience alone can show which treatment is most advantageous.—*British Medical Journal*.

THE SINGLE SUTURE IN LACERATED PERINEUM.—Dr. T. Johnson Alloway, of Montreal, in an article on this subject in the *Am. Jour. of Obstetrics*, January, 1884, concludes as follows:

1. Examine carefully, *with your eyes*, every perineum after removal of placenta. If lacerated to more than a quarter of an inch, apply the suture.
2. Use one of Emmet's long, straight perineum needles, with a silk suture. By the aid of a holder, force the needle through the skin on the left side of the tear, half an inch from its edge, at any point between the beginning and end of tear, but the nearer to the beginning, that is, the higher up, the better will be the result. Now,

with the two fingers of left hand in the rectum, press up the rectal wall and recto-vaginal cellular tissue, so that the needle can be rapidly, though steadily, made to glide beneath this tissue and over the rectum, hugging the latter as closely as possible to make its exit at a corresponding point on the opposite, or right side. In tying the suture, avoid doing so too tight, as it is a good plan to allow for swelling, which generally lasts for some days.

3. Be sure that the needle in no part of its course makes an exit in the vaginal surface; if so, you will probably have a pus pocket.

4. The operation is very simple, and can be performed by any physician of ordinary experience.

5. The after-treatment consists in washing out the vaginal passage night and morning with any antiseptic solution the physician is accustomed to use. *But he must do it himself*; the nurse would be as likely to pass the tube below as above the suture, *and kill all your joy*. As regards antiseptics, I use in such cases a solution of corrosive sublimate $\frac{1}{1000}$ once in twenty-four hours, administered at night. I find this solution as handy and harmless as carbolic acid. Tell your chemist to make a 3ij. alcoholic solution of hyd. bichl., each drachm of the solution to contain seven and one-half grains of the salt. One teaspoonful of this mixture added to a pint of water will give, almost to a fraction, one part in one thousand. I have used this solution in cases of metria three times in the twelve hours for two consecutive days without any evidence of toxic effects from absorption. It is probably due to the formation of an insoluble albuminate of mercury, which seals up all breaks in the surface for a time.

6. The suture had better be allowed to remain in situ for nine or ten days. I am strongly in favour of the silk; the wire suture is liable to produce a bleeding point or two on removing it. This accident might prove troublesome from absorption, which is so active at this period of convalescence.

7. The nurse is the only assistant you will require, and is, of course, in your confidence.

HIGH AMPUTATION FOR SENILE GANGRENE.—Mr. Jonathan Hutchinson read a paper on this subject before the Royal Med. and Chir. Society of London, of which the following is a resume: (*Lancet*). It began with the statement that the author's chief object was to urge the safety and expediency of amputating in senile gangrene if the operation were done at a great distance from the disease. In the common form of gangrene of the toes and foot, the lower third of the thigh was the part suggested as the proper level of the amputation, and in rarer cases in which the hand was affected, the middle of the upper arm. After remarking on the fact that amputation had hitherto generally proved disappointing owing to return of

the disease, the author urged that this was owing to their having usually been done too low down. The calcification of the arteries upon which, in the main, the disease depended, was usually greatest near the periphery, and hence the difficulty as to supply of blood for the nutrition of the flaps. This source of danger was not met with if the amputation be done sufficiently high. In a series of cases, in very old patients, the author had not encountered the recurrence of gangrene excepting in one. In three the stump had healed well. In a fourth, in which the patient, although not old, was prematurely senile and the calcification of the arteries extreme, the recovery had also been excellent. In this instance the femoral artery was so rigid that it stuck out from the face of the stump like a small bone. One of the patients, in whom the stump had healed without a drawback, was seventy years old. In two of the cases the other foot had been subsequently threatened with gangrene. As to the time to be selected, the author thought that as soon as the patient was so ill as to be confined to bed and the disease was well established, it was best to operate. Spontaneous cure was, he urged, very exceptional, and a great majority of such cases ended in death after a long period of much suffering. The thinner the patient the less was the risk of the amputation. In a few cases in which the thigh was exceptionally fat and the tissue flabby, it might be wise to hesitate as to recommending it. In all cases Lister's precautions had been carefully used, and in two or three the patient had never experienced the slightest pain from the day of the operation.

EXTRA-PERITONEAL PERI-UTERINE HÆMATOMA.—A recent number of the *Zeitschrift für Geburtshülfe und Gynäkologie* contains a long article bearing the above title, by Dr. A. Martin, of Berlin. This author believes that cases of the kind which the title denotes, present characters distinct enough for their separate identification. He describes four cases, in which the nature and exact seat of the disease were made certain by operative exploration. He quotes three other cases, in one of which the same diagnosis was established by operation, and in two by autopsy. From this basis, he gives the following as the characteristic features of this form of disease. First, the local signs. The uterus is very definitely displaced laterally, and generally pushed forward as well. The tumour formed by the effusion is not in the middle line, but occupies one side only of the pelvis, so that on the opposite side the examining finger detects no abnormal signs. On examination per rectum, the lateral position of the tumour can be made out with precision, and when the posterior surface of the uterus is explored with the finger, it can be ascertained that the effusion is not situated between the uterus and the rectum.

in other words, that Douglas's pouch is empty. Next, the symptoms. The commencement of the illness is sudden, and marked by abdominal pain, hæmorrhage, and signs of collapse: but the symptoms characteristic of peritonitis—vomiting, distension of the belly, pyrexia—are absent. Believing that he has thus established the diagnostic signs and symptoms of this form of disease, Dr. Martin proceeds to apply his generalizations to other cases, in which the diagnosis has not been made clear by post-mortem examination, or operative exploration. He has collected from literature eleven such, and from these, together with the verified cases before mentioned, he proceeds to describe the etiology, pathogenesis, anatomy, symptomatology, differential diagnosis, prognosis, and treatment of the disease. It seems to us that all our author has to say, that is at once important and novel, is based upon the cases in which the diagnosis was established beyond doubt; and therefore we refrain from further epitome. We may mention, however, that he regards the diagnosis between an old extra-peritoneal hæmatoma and a subserous fibroid, in the absence of a reliable history, to be quite impossible.—*Med. Times and Gazette.*

DISLOCATION OF THE TENDON OF THE BICEPS.
—In *The American Journal of the Medical Sciences* for January, 1884, Dr. J. William White reports a case of this form of luxation, and reviews the history of other cases of the same nature. The symptoms in Dr. White's case, which led him to the conviction that there had been true traumatic luxation of the bicipital tendon, may be enumerated as follows:

1. The recognition of the bicipital groove, empty, which, if its existence be admitted, is pathognomonic.
2. Recognition of the tendon itself.
3. The inward rotation of the arm.
4. A slight depression under the tip of the acromion, a prominence of the shoulder in front, and a flattening behind.
5. Diminution in the vertical circumference of the shoulder.
6. Shortening of the arm as measured from the tip of the acromion to the external condyle.
7. Elevation of the shoulder, tilting up of acromion, and elongation and narrowing of axilla when the arm was carried upwards.
8. The peculiar depression situated over the bicipital groove.
9. The line of ecchymosis following and strictly limited to the course of the biceps muscle.
10. A creak or "squeak," heard distinctly on carrying the elbow away from the side.
11. Flexion of the forearm on the arm was painful, the pain being sharp, lancinating, and felt at the front of the shoulder; flexion during supina-

tion was much more painful than flexion during pronation.

12. When extension of the forearm was attempted, a tense line along the edge of the biceps could be both felt and seen.

13. The pain felt over the joint was also felt along the line of the biceps as far as its insertion, and the patient still has a "drawing" sensation over that region.

14. The arm was preternaturally mobile for some time after the accident.

15. The position of the patient after the accident.

16. The character of the force producing the difficulty.

The rationale of these symptoms is very fully explained.

NOTE ON HYOSCYAMINE.—Dr. R. A. Hayes, of Dublin, Ireland, reports ("Dublin Journal of Medical Science," December, 1883) a case of tremor of the left arm which he treated with hyoscyamine. The patient, when he came under Dr. Hayes' care, had been troubled with this tremor for six months. Eighteen months before it came on he had suffered an injury of the shoulder of the same side. He was given one sixteenth of a grain of hyoscyamine in pill. A single dose daily for two days produced no effect on the tremor. Next day two doses, morning and evening, relieved the tremor in some measure. The following morning a dose of one eighth of a grain was given. Delirium soon supervened, and continued through the day, but the tremor ceased. The next morning one sixteenth of a grain was followed by delirium, which did not completely pass off until the following day; but the tremor was decidedly controlled. The drug was now discontinued, it having completely paralyzed the patient's accommodation and interfered seriously with his sleep. The tremor returned at once, and soon became very marked. Three days afterward the hyoscyamine was resumed in doses of one thirty-second of a grain three times a day. In two days the tremor was lessened; in six days the ciliary muscle had again become paralyzed, and the medicine was stopped at the patient's request, though the tremor was much relieved. The smaller doses, while they did not effect the pupils, paralyzed the accommodation so completely that reading was impossible. It should be stated, however, that, when the administration of hyoscyamine was begun, the patient's eyes had not recovered from the effects of atropine, which had been used to facilitate an ophthalmoscopic examination.—*N. Y. Med. Jour.*

TO ABORT MAMMARY ABSCESES.—In the *Lancet*, for Dec. 15, 1883, will be found an article by Dr. James Braithwaite, in which he says: "In cases of threatened mammary abscess, I have for

many years, with very successful results, given three consecutive doses of ten grains of quinine at intervals of twelve hours, at the same time using the usual local application of belladonna. The administration of quinine in these cases, although its anti-suppurative power is well known, is not practiced by any one with whom I have conversed, but I have myself found it so successful, that I think it deserves to be in general use, especially as the disease is so painful and so exhausting to the system. The best cases for the treatment are those occurring during lactation, and it is less suitable immediately after labor. It is unsuitable if the bowels are confined and the tongue furred. There are some patients who do not bear such large doses of quinine, in which case a first dose of ten grains may be followed by two of five grains each. I originally saw this treatment recommended in a French medical journal, and claim therefore no originality. I have frequently seen the pain and tenderness disappear within forty-eight hours although a little hardness will remain for some days or longer, and the inflammatory symptoms may recur, and may be again at once checked by the same treatment. A recurrence, however, is rendered less likely if the belladonna is continued for a time, although pain has ceased. No doubt some will say that the success of the treatment is owing to the belladonna, and not to the quinine. I used the belladonna for years before I used the quinine in addition, and was struck with the greater rapidity and certainty of the result when the quinine also was used. At the same time I admit the difficulty, when two drugs are employed, of apportioning to each its real value."

TREATMENT OF ECZEMA OF THE GENITALIA—In cases of eczema, in which glyceroles and unguents have failed, the following formula has been successful.

R	Chlorate of potassium,	grs. xxx,
	Wine of opium,	grs. l,
	Pure water,	Oij.

Applied to the parts by linen compresses covered with oiled silk. If there is much inflammation, precede this with warm hip-baths and cataplasms sprinkled with powdered carbonate of lime. Is obstinate pruritus, associated with leucorrhea, a tablespoonful of a mixture of equal parts of tincture of iodine and iodide of potassium, in a quart of warm tar water (tar-water holding the iodine in solution), used daily, night and morning, removes the pruritus and ameliorates the leucorrhœa. In fetid leucorrhœa, two or three tablespoonfuls (in a quart of warm water, morning and evening, as an injection) of the following formula will be found useful.

R	Chlorate of potassium,	parts xiiij,
	Wine of opium,	parts x,
	Tar-water,	parts ccc,

Or,

White vinegar (or wine),	parts ccc,
Tinct. eucalyptus,	parts xlv.
Acid salicylic,	part j,
Salicylate of sodium,	parts xx.

One to five teaspoonfuls in a quart of warm water, as an injection, two or three times a day.—

Obstetric Gazette:

TREATMENT OF VARICOSE VEINS.—Mr. Folker describes, in the British Medical Journal, a recent operation he performed for the cure of varicose veins. In the operation the vein was securely tied, and ultimately obliterated, without any disturbance of the surrounding parts. The man was operated upon on Saturday, and the following Tuesday week (eleven days) he was up in the ward. The operation was as follows: A small incision was made on each side of the vein, and a curved needle, passing in at one incision and out at the other, carried the ligature under the vein, and was withdrawn. A flat instrument was now, in the same manner, passed in at one and out at the other incision, and threaded with one end of the ligature, which then, by its withdrawal, passed the ligature over the vein. The two ends of the ligature, which now surrounded the vein, projected through one opening. This was repeated in as many places as might require it, and then the lowest one was tied first, and the ligature cut off close, firm pressure was made over it just to press out any drop of blood that might be present, and the little opening was closed with collodion. Each ligature from below upward was tied in a similar way, pressing the blood out of the vein up to each ligature before tying it. The ligature used in the present case was pure silk, well carbolized; but Mr. Folker hoped to tie some with tendon ligatures which would become thoroughly absorbed sooner than the silk.—*Lou. Med. News.*

USE OF COLLODION.—Mr. Sampson Gamgee, *Birmingham Medical Review*, says: To swollen parts which can not well be bandaged, collodion is especially applicable for the compression attending its contraction. I was lately consulted in the case of a good looking boy considerably disfigured by a red and swollen nose, which became very pale and visibly contracted just after I painted it with successive layers of collodion. I repeated the application three times in the succeeding fortnight, with the effect of producing shrinkage of the organ to its natural size and color.

When the nasal bones are fractured, a very effective mould for keeping them immovable, after adjusting them with the fingers, may be thus made: place over the nose a thin layer of absorbent cotton soaked in collodion; as it dries another layer of cotton and more collodion, taking care that the application extends sufficiently on each side to

give a buttress-like support. The patient compares the feeling to the application of a firm bandage on the nose, and the bones consolidate effectively under the shield, which may be renewed as it cracks and peels off.

GOETZ'S SUTURE INSTRUMENT WITH ENDLESS THREAD.—This instrument combines in one needle, needle holder, ligature thread and disinfectant. It consists of a hollow cylindrical part,

A D, holding at the end D a reel, upon which silk is wound and to which at c the cap B is to be screwed. The hinge at c facilitates filling of the cap B with carbolized oil or any other disinfectant, whilst the part D of A is in the cap. At c there is a washer which prevents leakage. The spool D is readily removable from its encasement for winding silk upon it whenever the supply has been exhausted. Through c there is a perforation by which the silk passes out of A D and directly to the eye of the needle which is near its point (in this respect the figure is incorrect—it appears as though the needle were hollow, which is not the case). A straight and curved needle go with the instrument, either of which can be attached straight forward or at right angles with the same. It can be readily seen how, after once threading,

this troublesome manipulation need not be repeated, regardless of the number of sutures to be made, as long as the supply of silk holds out, which, when the spool is fully charged, is sufficient for several large operations.

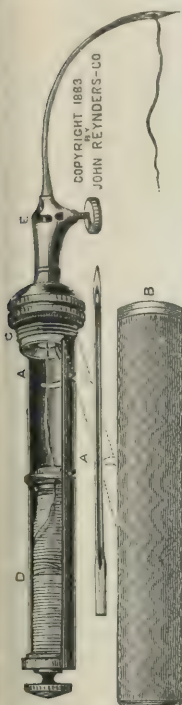
MICROBOMANIA.—The symptoms and effects of this malady are wittily described by M. Paul Somans in the feuilleton of a recent issue of the *Gazette Médicale de Paris*. He speaks of it in connection with the numerous maladies which have recently been described, such as agoraphobia, claustrophobia, and morphiomania. Microbomania is an affection of adult or middle age, sometimes attacking those in advanced years. It is most frequently observed among educated physicians, those most given to biological research, and almost always ambitious. It is characterized at the *début* by a great desire for notoriety, accompanied by a slight degree of fever and a craving to find certain mobile corpuscles. The desire is soon followed by acts calculated to satisfy the special craving. In the end hallucinations are developed as to the

presence of corpuscles in impaludism, measles, scarlatina, even in mumps, and the minute organisms are charged with all the crimes imputable to each pathological individuality. The disease is imitative, and if several individuals under the influence of this form of mania should concentrate their attention on one and the same disease, they are very apt to find widely differing microbes.—*Med. Press, Jan. 9.*

HYPERICUM OIL FOR THE PREVENTION AND CURE OF BED-SORES: Dr. Herbert L. Snow writes in the *British Medical Journal*: Since my note on this subject in the *Journal* of December 8th, I have been favored by Mr. Fenn Clark, honorary consulting-surgeon to the Leamington Provident Dispensary, with a communication, from which I subjoin the following extracts: "I see that you have alluded to the value of hypericum oil. May I be allowed to add my testimony as I have made and used it in my practice for the last twenty years, with manifest advantage in severe cases of bed-sore? It is an old favorite in this country; and our American friends think highly of it also. I observe that you recommend a few days as the time which hypericum oil will require to perfect it. May I mention that my friend, who first introduced it to Mr. Garrard, and to Leamington generally, always recommended a period of three months in a sunny window, as it could not in less time acquire the reddish-brown tint? It is prepared from the blossoms of the *Hypericum medium perforatum*, which flowers in July."

SPONTANEOUS DISLOCATION OF THE HIP JOINT OCCURRING IN THE COURSE OF ACUTE ARTICULAR RHEUMATISM.—Dr. Stimson also presented a woman, thirty-seven years of age, who had an attack of rheumatism in December, 1882. The history of the attack was obscure, but the patient said that many joints were involved, that she remained ill for a long time, and that the deformity occurred as early, at least, as the following April. She finally came to Bellevue Hospital last summer, where Dr. Stimson saw her first in the month of September, and recognized a dislocation of the right hip joint backward upon the ilium. The interest of the case was partly in the rarity of the occurrence, and also in the facility with which the lesion might be overlooked. The subject had been recently written upon by French surgeons, and he had nothing to add except to say that the symptom of sudden cessation of pain, sometimes noted at the moment the dislocation occurred, did not appear to have been present in this case.—*N. Y. Med. Journal.*

CHARCOT'S CREED.—If I believe firmly that there exists in medicine a domain which pertains entirely to the physician, which he alone can culti-



vate and fructify, and which must necessarily be closed to the physiologist who systematically confined to his laboratory, disdains the instruction of the hospital wards, I no less firmly believe that the free intervention of the anatomical and physiological science in the affairs of medicine is an essential condition to its progress. I believe that practical medicine is not a real autonomy; that to live it must borrow; that without a constant scientific renovation it would soon become a dull routine. I think finally, that as regards the qualities of quick-sightedness, ingenuity, and practical skill, which all have to be perfected by use, and are not bestowed in completeness by nature, these are as much needed by the pathologist as by the clinician. This, very briefly, is my *credo*. I have always held to it, and I must always continue to do so.—*Medical Record*.

THE MICROCOCCUS OF PNEUMONIA.—In the sputa from fourteen cases of pneumonia (*Prof. Salvioli and Dr Zaslein*,) were found constantly ovoid cocci analogous to those described by Friedländer; they were frequently joined; seldom isolated; mostly in threes, fours, or in masses. The best staining material for them is a mixture of Bismark-brown and methyl-violet. They were first discovered about the third day of the disease though sparse, then becoming quite numerous about the sixth or seventh day, or when resolution begins and the râles return; later their number lessens and about the ninth or tenth day they disappear. The number of the micrococci, is independent of the severity of the disease or the height of the fever. The same organisms were found in the serum of fly blisters and in the patient's blood. By keeping the blood or serum in a warm place great increase in the number of the cocci was attained. Sputa from patients suffering from other affections of the respiratory apparatus, as well as blood and serum from persons free from pneumonia never contained these germs.

The pneumonic cocci were cultivated artificially by the authors. They obtained the best results with meat broth at about 100° F. as a culture fluid, having previously sterilized it by boiling. The cultivated cocci from the second to the fifth generation were injected under the skin of white mice and rabbits with the result of producing typical pneumonia; injection into the pleural cavity caused pleuritis with fibrinous exudation in which numbers of the organisms could be found.

Injection of the culture fluid without the cocci failed to produce pneumonia. It seems from these experiments that there exists in the sputum, blood and serum of pneumonia patients a constant germ, which can be cultivated through several generations and still have the power of producing typical pneumonia in animals when injected under the skin.—*Centralblatt f. d. Med. Wissenschaft*, No. 41, 1883.—*New England Med. Monthly*.

ST. JOHN LONG'S LINIMENT.—This old time liniment is still in use at the Pennsylvania Hospital, in this city, for stiff and rheumatic joints, and in general for cases in which a local stimulant and rubefacient effect is desired. Mr. Jacob Hecker, Ph. G., the apothecary of the institution, uses the following formula:

R Vitelli ovi, no.viii
Olei terebinthinæ,f 3 xxiv;
Acidi aceticæ.....f 3 xvj;
Aquæ.....f 3 xxiv.

M.

The directions for its preparation are as follows: To the yolks, in a gallon bottle, add a small quantity of the water, and shake briskly together; then add the turpentine in successive portions, shaking the mixture briskly after each addition; then add the acetic acid, and lastly the water, in the same manner. For private practice the liniment is greatly improved by the addition of one drachm of good oil of lemon to each pint.—*Med. Times*.

IRON IN THE TREATMENT OF SKIN DISEASES.—Casarini has employed the perchloride of iron with advantage in a large number of chronic skin affections. He uses an ointment of from one to three grams of perchloride of iron to thirty grams of lard. He concludes from a number of observations that: 1. Perchloride of iron (internally administered) is the most efficacious agent in the treatment of simple or hemorrhagic purpura; 2. it is very useful to combat the anæmia which often accompanies certain cutaneous affections, such as rupia, ecthyma, and impetigo; 3. its external employment gives excellent and speedy results in ulcers of scrofulous and syphilitic origin; 4. in the form of ointment it constitutes a good remedy in the squamous skin diseases, especially in psoriasis. *Journal de Médecine de Paris*. November 24, 1883. *Med. Record*.

KAIRIN.—The *Lancet*, April 14, 1883, says that Filehne, in a recent number of the *Berliner Klinische Wochenschrift*, calls attention to the value of derivatives of chinoline which he with Fischer and König, has found of great value as an antipyretic. These are kairin, kairolin, and finally chinolinæ hydrate of Wischnegradsky. Of these kairin seems most likely to be of permanent value as an antipyretic. The muriate of kairin is a crystalline, clear, grayish-yellow powder, soluble in water, having a bitter, saltish, aromatic taste, which is disagreeable to some patients, and is therefore given in wafers, with a subsequent drink of water. Filehne gives five to seven grains every hour or hour and half. The remedy has shown a marked control over the temperature of croupous pneumonia. The urine, when kairin is being given, becomes dark green.

DR. H. C. WOOD'S SYPHILITIC TEST.—Persons are often unaware that they are suffering from syphilis. They honestly believe that they never had primary or secondary symptoms; these symptoms may, however, have been present, but so slightly marked as not to attract attention. Again, this is one of the points about which human nature often fails. People, even when death is staring them in the face, and their lives hang upon the truth, will make false statements. As we have a touchstone by means of which we are able to decide whether or not a patient is suffering from cerebral syphilis, I ask no questions, but apply the test where I have reason to suspect any disorder. It is a serious matter to mercurialize a patient, but it does no harm to produce iodism, so that when making the test I always employ iodide of potassium. If I find that ten grains three times a day produces symptoms of iodism I am almost sure that the case is not one of specific disease. If, on the other hand, the patient takes from one-half to one drachm of iodide of potassium and waxes fat thereon, I am almost sure that he is the subject of specific disease. There are some persons, not syphilitic, who will stand large doses of iodide of potassium, but such cases are rare, so that when a patient will take half a drachm of the remedy three or four times a day it may be concluded that he is syphilitic. I say this with one reservation. Persons who have gradually accustomed themselves to the use of iodide of potassium, as for instance, those who are asthmatic, will stand large doses of this drug, even when not suffering from syphilis. In such a case there will be the history of the long-continued use of the remedy. You must remember, also, that there is a syphilitic asthma, so that the relations of iodide to potassium to asthma are in many cases easily explainable. I shall speak of the method of using iodide of potassium when I come to consider the treatment.—*Gaillard's Med. Journal.*

THE DIET IN BRIGHT'S DISEASE.—In the *Chicago Med. Jour. and Ex.* Dec., 1883; Dr. Purdy suggests as the diet for the albuminuric patient the following: In the main it should consist of farinaceous articles, fish, vegetables, and fruits. Meats must be indulged in sparingly; very small quantities of lean meat alone being permissible. Soups should be prohibited; even the conventional beef-tea and beef extracts. Eggs should be excluded from the diet in albuminuria. It has been shown by Lehmann and Stockvis that when the white of an egg is introduced into the circulation, not only does that escape by the kidneys, but a surplus of other albuminoids accompanies it. Senator says the lesson will apply to meat as well as eggs. "Any excess acts in two ways injuriously—by increasing unnecessarily the amount of urea and other waste products in the blood; and also by pouring into the system an overplus of peptones

or other albuminous matters, which may simply have to be excreted, and cause irritation in the act." Cheese acts in a similar manner, and should not be used. Vegetables may be used freely, and the only ones to be avoided are the leguminous ones, which are too rich in albumen. Fats may be used as freely as the condition of the stomach will permit. Milk is one of the best articles of diet, but should not be too exclusive, as it does not furnish the elements of diet in a suitable proportion. The stomach should not be everloaded, it being an occasional observation that even in healthy persons albumen appears in the urine after a large meal. Small meals, more frequently repeated than usual, is a good rule to follow in such cases. Great discrimination is necessary in the matter of drinks in Bright's disease. Alcohol in large quantities, especially in concentrated form, is generally believed to be injurious. If alcohol be permitted at all, it must be well diluted, and it is preferable to give it with some alkali or neutral water, as Vichy or Apollinaris water in excess. Alcohol stimulates the interstitial changes in the kidneys if used in quantities, hence the allowance should be very small—not enough to disturb to any extent the general circulation. Claret, sherry, and Marsala are the least objectionable. As to malt liquors, they should, as a rule, be excluded, though it is stated that lighter pale ales or Bavarian beer are nearly free from objectionable qualities.

INJECTIONS INTO THE UTERINE TISSUE.—Dr. Schücking proposes to treat certain maladies of the uterus by injecting the medicament directly into the substance of the organ. We believe that this expedient, which he brings forward as new (*Berliner klin. Wochen.*), has been often employed in this country. The advantages of this method are two: it is local; it causes much less pain than subcutaneous injections. The remedies so employed are ergotin, Fowler's or Pearson's solution of arsenic, tincture of iodine, carbolic acid, and some other agents. The principal diseases thus treated are subinvolution, chronic metritis, fibroids, and some forms of displacement. For the performance of this operation the ordinary hypodermic syringe suffices, but the needle must have the necessary length to reach through the speculum into the uterus. Only concentrated solutions are suitable, since the tissue of the organ is too compact to admit more than a few minims.

That this method is not a mere fancy is proved by its employment in this city at the present time. We happen to know that a competent and enterprising female physician is using in this way a solution of carbolic acid, five per cent. in strength, for the relief of uterine cancer. The solution is freely injected into the tissue immediately subjacent to the cancerous mass. Too short a time has transpired to permit any opinion as to the ultimate result of this method.

TRACTION SUTURE.—Dr. Allis, (*Annals of Anat. and Surg.*), says that when a large portion of integument has been cut away, as in removal of the female breast, the healthy borders sometimes can not be fully approximated; and even an attempt to do so is accompanied with such a degree of tension that the sutures soon cut their way out. To distribute this tension, after drying the skin thoroughly, he applies strips of adhesive plaster from the margin of the wound in the direction he wishes the sutures to hold. He then passes his needle deeply through plaster and skin. After the sutures are in position, and before tightening them, he requests an assistant to approximate the margins of the wound by pressure from his hands, while he secures them by twisting the wire.

Sutures employed in this manner have a firm hold upon the plaster, exert their traction upon a large surface, are less irritating and harmful, and will continue an efficient action much longer than the ordinary integument sutures.

YELLOW OXIDE OF MERCURY OINTMENT IN CORNEAL ULCERATION.—Jonathan Hutchinson says "I do not doubt that there are at the present moment, whilst I am speaking to you, in the homes, the schools, the workhouses and the hospitals of England, some thousands of children who are suffering from ulcerations of the cornea, attended with intolerance of light, causing the patient great distress through many months and destined often to leave disfiguring and incapacitating scars. If my own experience may be trusted, I believe that three-fourths of these would be almost well in the course of a fortnight under the use of a very weak yellow oxide of mercury ointment. Since I knew the virtues of this ointment, I have been able to abandon almost entirely the use of blisters, setons and like painful measures and to effect the cure in the tenth of the time"—*Brit. Med. Journal*, Oct. 20, '83.

DECALCIFIED BONE DRAINAGE TUBES.—Prof. Gross gives the following directions for making decalcified bone drainage-tubes. Procure the femora and tibiae of a chicken or turkey, take off the periosteum, and place the bones in 16 $\frac{2}{3}$ per cent. solution of official hydrochloric acid until they become soft; then cut off the ends and force out the endosteum; replace in the hydrochloric acid solution until they become very soft; fill them with horse-hairs, which must be removed if pus forms, as they will not allow it to pass. However, he recommends removing the bone tube in twenty-four hours, as it can only be absorbed by granulations, which render union by first intention out of the question.—*College and Clinical Record*.

Prof. Bartholow (*Col. and Clin. Record*) strongly

recommends salicylic acid, either by injection or internally, in large doses, for cystitis. Administered by the mouth, it acts after being excreted in the urine. He also says that potassium tartroborate has been found effective—more effective, probably than any other remedy—in causing the solution of uric acid calculi. The treatment is to be long continued, in small doses, dissolved in much water.

ANTISEPTIC INHALATIONS IN PHTHISIS.—This method of treatment is not particularly new, but its use has been deprecated by many, on the grounds which are noted by Dr. I. Burney Yeo, in the *Brit. Med. Jour.*, January 12, 1884, as follows:

"Two objections have been made to the use of antiseptic inhalations, which are in singular opposition one to the other.

"The first is, that the vapors given off from the fluid which we drop on the sponge of the respirator are so strong and irritating, that they excite inflammation of the pulmonary tissues, and thus do injury; indeed, I have seen the antiseptic treatment of phthisis referred to in a medical journal as 'homicidal.'

"The other objection does not accuse of homicide, but is content with pointing out that we are very foolish people to imagine that any useful or appreciable amount of our antiseptic substances reaches the lung at all! I do not know which of these objections is least in accordance with experience.

"With regard to the first objection, I can state most positively that I have never seen any symptoms of irritation set up by antiseptic inhalations when properly applied. In sensitive persons, it is desirable to begin by at first dropping a few drops of the inhalant on the sponge, and slowly increasing the quantity; by that means, you will avoid all risk of irritation.

"The second objection scarcely needs answering at all; to some extent, it is a resurrection of the old dispute as to the use of topical remedies (in the form of vapors and sprays) to the respiratory surface, which was agitated fiercely many years ago, and the affirmative view thoroughly established by most elaborate and careful experiments by a number of observers in every country in Europe. The dispute and its results are fully related by Oertel in the work already referred to, and also by Dr. Solis Cohen, of Philadelphia, in his work 'On Inhalations.'

He has had good results, and after reading his paper, we would feel inclined to give a trial to the inhalation of a weak solution of corrosive sublimate, say 1 to 2000 or 2500, by means of a steam atomizing apparatus.—*Med. and Surg. Reporter*.

THE CANADA LANCET.

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AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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The LANCET has the largest circulation of any Medical Journal in Canada.

ERGOT IN OBSTETRIC PRACTICE.

The place which ergot holds in obstetric practice at the present time is in marked contrast with the teaching and practice of a few years back. It is not long since ergot was given to the parturient woman in the most hap-hazard manner. Indeed there is room for the belief that some fossils in the profession continue to use it in that way still. Of course it has long been known that ergot contained elements of danger both to mother and child. Still it is but recently that the full gravity of these dangers has dawned upon the profession. More specially within the last year, this question has been studied and debated with the liveliest interest, with the result of modifying former opinions and practices in several essential points.

When ergot is administered at an earlier period than towards the close of the second stage, it is thought to hasten delivery by whipping up a lazy, tired-out uterus, to the exercise of greater contractile force. The most serious danger to be apprehended from such a practice, is rupture of the uterus. The possibility of this untoward circumstance has long been known, but its occurrence was thought so rare that many obstetricians were willing to incur the risk. That this accident is not so very rare as generally supposed, may be inferred from the fact, that at a meeting of the St. Louis Medical Society recently held, one gentleman testified that he had seen six such cases, and another that he had seen two, within a year, all attributed to ergot. Another and more frequent

danger is the loss of the child. Not even every veteran obstetrician has witnessed a case of rupture of the uterus, but almost every practitioner has seen more than one child born dead, with darkened skin and swollen features, proclaiming louder than words the cause of death. Standing in the glare of the light of the present day, and looking back into the past, every practitioner of experience must be struck with dismay at the number of serious casualties observed in the path over which he has trodden. Untoward occurrences, then either held to be unaccountable or attributable to other causes, are now unveiled and shown to have been often the evil work of ergot. Of course the uterus may rupture, and the child may be still-born from other causes, but there is good ground for believing that most of these accidents, especially the former, result from the abuse of this drug. Violent and continued contraction, when it fails from any cause to expel the child, creates a liability to rupture, and prolonged pressure destroys the child by constricting the circulation.

Another and dangerous mishap sometimes following the administration of ergot, is irregular contraction; that is, the contractile force is not equal in all parts. When this happens, as it often does, however severe the maternal suffering may be, labor is just as likely to be retarded as advanced. This retardation may arise from one of two causes, or both at the same time. First, the contractile force exerted in certain zones may be rendered abortive by the inertia in other zones of the uterus; and secondly, labor may be retarded, and even made impossible, by a change in the direction of the expulsive force.

Then there is the danger of a lacerated cervix and a ruptured perineum. The former accident has received a good deal of attention of late from gynecologists, owing to the serious dangers and suffering to which it gives rise. Many troubles of the cervix not formerly understood are now known to originate in laceration. Laceration, of course, may occur without the use of ergot, but common sense teaches us that it is more likely to occur in rapid and violent dilatation, such as may follow the administration of ergot. The same remarks are applicable to rupture of the perineum, an accident often fraught with life-long suffering to its victim. It is not here pretended that these are novel facts. On the contrary they have been long known, but

somehow, it is but recently that their full significance has come to be realized.

The question now arises, has ergot any longer a place in midwifery practice? It certainly has, but its application is comparatively limited, and most carefully guarded. A few, indeed, have gone so far as to abolish it altogether, in all stages of labor, and use it only as a post-partum remedy. A large number hold that it ought not to be administered before the second stage of labor is passed, but that it may then be profitably given to facilitate the expulsion of the placenta, and to secure firm contraction. But the opinion more generally held, and the one practised by many of those allowed to speak with the weight of authority is, that after the head is born, it is not only safe but good practice to administer a full dose of ergot. Indeed it is now frequently the practice to administer ergot at this stage, or as soon after as possible. The object of course is to secure firm contraction so as to expel the placenta and prevent possible hemorrhage. Firm post-partum contraction is highly desirable in all cases. It empties the uterus of clots and remnants of membranes which otherwise might remain and cause much serious trouble. It is now known that severe and continued after-pains are owing to imperfect contraction, and that the more firmly the uterus is contracted the less severe these are likely to be. For this reason also it is good practice to administer ergot towards the close of labor in all cases, experience having abundantly proven that the after-suffering is thereby greatly diminished. After a time, should the after-pains be severe, a good plan is to combine opium with the ergot. Indeed so valuable is ergot at the close of labor that in many cases to neglect to administer it is only less criminal than to do so at an earlier stage. In all cases where there is reason for believing the uterus has not properly contracted, ergot should be steadily given for some time, combined with citrate of potassium, adding bromide of sodium when nervous symptoms are present.

But the most important office ascribed to ergot is in relation to post-partum hemorrhage. We have already referred to its use, in anticipation of the occurrence of that untoward and much dreaded accident, and doubtless its power to prevent this occurrence is much greater than its power to control it when it has actually taken place. We think every experienced practitioner will bear us out in

the statement that ergot is very uncertain in its action during the occurrence of hemorrhage.

Therefore the greater necessity for availing ourselves of the known power of this agent to prevent this accident. We may readily surmise causes for the comparative powerlessness of ergot to induce contraction after hemorrhage has taken place. The mental condition of the patient, the sudden prostration, and general loss of muscular tone, all render it improbable that the stomach is in a fit condition for speedy absorption, if at all. Under these circumstances the ergot should be administered hypodermically, for the well known reason that agents act more speedily and surely when introduced in that way. For this purpose care should be taken to keep on hand a clean and pure article. The so-called liquid ergot recently introduced, is a good and convenient form. Under all circumstances where it is important that action should be both speedy and certain, the hypodermic method should invariably be practised.

But the question will be asked, what are we to do when the os is fully dilated, the membranes perhaps ruptured, and the pains either feeble or entirely absent. In such cases we may safely exercise the virtue of patience, in the absence of all alarming symptoms. It may be that a little rest is all that is needed, and for that purpose a dose of opium may be given, although, instead of giving rest, it may, perchance, set up active contraction, ending in speedy delivery. Large and repeated doses of quinine, are both safe and effective in promoting uterine action, and should be resorted to when it is thought necessary to secure greater contractile force. Gentle external manipulation is also valuable in promoting contraction. But should all these means fail, and active interference called for, the safest resort is the forceps, followed by ergot, administered hypodermically to insure speedy and firm contraction.

MEDICAL SUICIDES.

A short time ago a charge was brought by the public prosecutor before the Central Criminal Court, London, England, against a woman named Hardie, for having procured her own miscarriage by illegal means and with the aid of her medical attendant, Mr. Haffenden. Feeling keenly the weight of the unjust accusation made against him

Mr. Haffenden sought delivery from his trouble by committing suicide. The case came before the court in due course, and after a trial lasting the whole day, a verdict of acquittal was declared amidst loud applause. The chief witness for the prosecution broke down in cross-examination, and that, combined with the entire openness of Mr. Haffenden's proceedings and the evidence of Dr. Robert Barnes, the only medical witness called for the defence, left no doubt in the minds of the jury that the charge could not be upheld. The *Medical Times and Gazette*, in commenting on this painful case, says: It is to be deplored that the prosecution was ever instituted, and it is still a greater matter for regret that Mr. Haffenden did not abide in life to see his reputation vindicated. The case, though reported so meagrely in the journals as to be useless for medico-legal purposes, will serve as a timely reminder—first, to the Public Prosecutor and his advisers never to bring such another charge against a medical practitioner without an overwhelming mass of proof; secondly, to pregnant women that it is something more than a peccadillo to destroy the fruit within their womb; and thirdly, to medical practitioners to be more wary in the use of the uterine sound. Ladies have been known to go to gynaecologists so well coached up in the symptoms of displacement that the sound has been introduced as a matter of course, and the doctor has not found out till afterwards that he has been made the subject of a plot."

We refer to this case for two reasons; first, because medical men, especially those who have to deal with diseases of women, are liable at any time to have charges trumped up against them, and therefore require to be constantly on their guard to surround themselves with every means of answering any false accusations that may be made against them; and secondly, to counsel medical men under all circumstances, if conscious of their innocence, no matter how dark the horizon may seem, or how damaging the slander may appear to be to their reputation, to fight it out. Let there be no compromise, and above all let there be no flying in the face of Providence by committing suicide in order to be delivered from impending trouble.

Many of our readers will remember the case of Dr. Edwardes, of Hounslow, who committed suicide about a year ago. In this case a charge of indecent assault was made by a Mrs. Bignell against

Dr. Edwardes, at the instigation of Dr. Whitmarsh, his partner, in order to drive the former into a disadvantageous and dishonorable dissolution of partnership. Instead of boldly meeting the charge and hounding down the villainous plotters, poor Edwardes, his quietus made, with a dose of prussic acid.

ANOTHER LIBEL CASE.—An action has been recently instituted by Dr. Lachapelle, editor of *L'Union Medicale*, against Dr. F. W. Campbell, *et al.*, of Montreal, to recover alleged damages incurred in consequence of a criminal action brought against the former gentleman. Some time ago an editorial appeared in *L'Union Medicale* to the effect that some French-Canadian medical students had received a private examination from the faculty of one of the medical schools of Montreal, and had received certificates which would enable them to practise in the United States. The drift of the editorial pointed to the faculty of Bishop's College as the guilty parties, and a criminal action for libel was brought against the proprietors of the journal in question. The bill, however, was thrown out by the grand jury, and the present suit has been entered by way of retaliation. The whole circumstance is much to be regretted, as it appears that both parties have been the victims of a fraud. The certificates referred to are believed to be forgeries.

HEALTH OF PANAMA.—Latest advices from this beautiful tropical city inform us that yellow fever prevails at present. In an article in the daily *Star*, written no doubt by Dr. Nelson, port surgeon, it is stated that while the disease is not epidemic, the fact of isolated cases occurring from month to month and from year to year, would point forcibly to the conclusion that the abominable neglect of all sanitary measures has allowed this disease to establish a permanent footing in their midst. The writer complains of the want of attention to sanitary matters, and says that with proper care Panama could be made one of the healthiest places in the tropics. It is hard to arouse the municipal mind to a sense of its duty. This is the experience of sanitarians in all parts of the world.

TRINITY MEDICAL COLLEGE TORONTO.—An official communication has been received by the authorities of this school from the Royal College

of Surgeons, England, enclosing the following resolution adopted by the Council of that body, formally recognizing the Fellowship Diplomas of the school. "That, as recommended by the Court of Examiners, Fellows by Examination of Trinity Medical School, Toronto, be admissible to the professional examination, for the Diploma of Member of the College on the same conditions as Graduates in Surgery and Medicine of recognized universities, as provided in paragraphs vii. and viii., section III of the regulations, and that, in consideration of the satisfactory examination, in medicine and midwifery, which such Fellows are required to pass, they be exempt from the necessity of passing in those subjects at this college." Such a recognition from such a quarter cannot but be very gratifying to the many graduates and friends of this school.

PATENT MEDICINE FORMULAS.—The following bill has been recently introduced into the House of Representatives of the United States: That from and after six months after the passage and approval of this act, no advertisement of any kind or nature or advertising device of any medical preparation, compound or prescription, or any punch, bitters, cordial or similar compound, or preparation to be used as medicine or mixed with food, liquor, wine or any other substance as a beverage or as food or medicine, shall be placed in or carried by the mails of the United States until the exact formula for the preparation thereof, together with a sample of the same, be placed in the Patent Office of the United States, with a sworn affidavit of the correctness of such formula and the genuineness of such sample, and the examination thereof by the proper officers designated therefor in said Patent Office.

APPOINTMENTS.—Dr. Marsden has been appointed a commissioner of the Marine Hospital, Quebec, *vice* Dr. James A. Sewell, deceased. The following gentlemen have been appointed "License Commissioners" (Act of 1876) for the districts named: J. S. Sprague, M.D., and J. S. Loomis, M.D., Hastings; J. Gunn, M.D., Middlesex; W. H. Blackstock, M.D., Simcoe; R. H. Abbott, M.D., N. Essex; A. McLean, M.D., W. Lambton; C. M. Gould, M.D., E. Northumberland; A. Robillard, M.D., Ottawa; A. Rockwell, M.D., of W. Hast-

ings. Thomas Moore, M.D., of Demorestville, has been appointed surgeon to the Canada Pacific Railway. Dr. Holmes, of Brussels, has been appointed treasurer of the Co. of Huron.

COSMOLINE UNCTION IN SCARLET FEVER.—There is scarcely anything so efficient in relieving the burning and itching sensation of the eruption of scarlet fever, as inunction of the body with cosmoline. It is applied by the hand once or twice a day as long as the itching lasts. These inunctions soothe and calm the patient, relieve the itching and favor desquamation. When the itching and burning sensations are allayed, the body should then be sponged with a solution of hypo-sulphite of soda, of the strength of half a drachm to the ounce. This removes all the desquamated skin, promotes healthy action, and acts as a disinfectant, thereby lessening the tendency to the spread of the disease.

NEW YORK STATE MEDICAL SOCIETY.—The seventy-eighth annual meeting of this society was held in Albany, commencing on the 5th ult., under the presidency of Dr. Alex. Hutchins, of Brooklyn. Many valuable papers were read and discussed. The bill for the establishment of a State Medical Examining Board was also under consideration. The vexed question of medical Ethics, the old code *versus* the "new," occasioned a prolonged and heated discussion. The advocates of the new code were again victorious, their majority being fifteen in a total of 232. Dr. N. A. Powell, of Edgar, Ont., was present as a delegate from the Ontario Medical Association.

ANATOMY ACT AMENDMENTS.—Steps are now being taken to secure certain much-needed amendments to the Anatomy Act, the object being to endeavor to secure a larger amount of anatomical material for the use of students and others interested in the prosecution of this interesting and important branch of medical study. The present Act is very defective in many particulars, and requires to be thoroughly revised and amended. It is the intention to frame the amendment upon the basis of the Quebec Anatomy Act, which, we are informed, is giving excellent satisfaction in the sister Province.

THE BERLIN POLYCLINIC.—The Berlin Polyclinic

nic has recently celebrated its first anniversary. During this time upwards of two hundred medical men have attended the clinic. The subjects taught are, diseases of the eye, ear, nose, throat, larynx, skin, nerves, etc., Each course consists of one month, and is of a most practical character. Laboratories for chemistry, histology and bacterioscopy have been fitted up and every facility afforded for special study in these branches.

SUBSTITUTE FOR TRANSFUSION OF BLOOD.—Dr. W. J. Bull, of the New York Hospital, referring to the use of saline injections as a substitute for transfusion of blood in acute anæmia and collapse, says, that of nineteen patients subjected to the operation, when at the point of death, thirteen entirely recovered. He uses the solution employed by Synmann and also recommended by Schwarz, consisting of water ℥xxxij , chloride of sodium ℥jss , carbonate of soda grs xv .

THIRD BLOOD CORPUSCLE.—Several observers have made reference from time to time to a third corpuscular element of the blood. Recently Dr. Osler, of Montreal (*Med. News*), has been making investigations which lead him to believe that there exists a third corpuscle about $\frac{3}{8}$ the size of the red globules. It can be seen in the vessels of the living animal, and in the vessels of freshly removed bits of tissue. When the blood is removed from the vessels they run together and form granule masses.

CANCER OF THE BREAST.—The following, which is said to be Dr. Hunter McGuire's formula, has been much extolled in the treatment of cancer of the breast, which has passed the period for successful operation.

R Sodæ et calcis Hypophos..... $\frac{3}{4}$ ss
Acid, phosph. dil..... $\frac{3}{4}$ ss
Aquæ ad..... $\frac{3}{4}$ viii

Sig.—A teaspoonful in water three times a day.

ERGOT AND MORPHINE IN ECLAMPSIA.—A hypodermic injection of half a drachm to a drachm of fluid extract of ergot and half a grain of morphine, has a most marked controlling effect upon puerperal eclampsia. The value of morphine in this way has been abundantly attested by numerous observers, and the combination with ergot is worthy of trial.

PILOCARPINE IN SCARLET FEVER.—In the *Glasgow Med. Journal*, Jan., '84, Dr. Shearer gives the report of a case of scarlet fever, followed by coma and convulsions, which he successfully treated with pilocarpine. He used it hypodermically in doses of $\frac{1}{3}$ of a grain, after having previously tried the usual remedies including the hot-pack, and has no doubt that the beneficial effect was due to the pilocarpine.

A VEHICLE FOR SALICYLATE OF SODIUM.—Dr. Solis-Cohen (*Med. and Surg. Reporter*) suggests the use of equal parts simple syrup and liquor ammoniæ citratis as a vehicle for salicylate of sodium, flavoring with oil of wintergreen. This also makes a good vehicle for the muriated tincture of iron, to a great extent hiding its chalybeate taste.

NEURALGIA PENCILS.—So-called neuralgia pencils are the latest novelty in Germany. They consist of a mixture of menthol, thymol, and eucalyptol, fused and fashioned into small conical pellets which are fixed in suitable handles. The part affected being touched with the pencil, a slight impression of burning is at first produced, followed by a pleasant, cool sensation, and immediate relief.

ONTARIO MEDICAL COUNCIL EXAMINATIONS.—The professional examinations of the Ontario Medical Council will take place early in April. The final examination begins on the first prox. in Toronto and Kingston, simultaneously; and the primary on the 11th in Kingston, and the 14th in Toronto. See announcement in another place.

BRITISH DIPLOMAS.—The following gentlemen have successfully passed the professional examination and were admitted Licentiates of the Royal College of Physicians, London, Eng. W. Graham, M.D., (Toronto); W. S. McConochie, M.D., and E. R. Woods, M.D., (Trinity); and J. B. Loring, M.D., (McGill).

The following gentlemen have recently passed the necessary examination and were admitted members of the Royal College of Surgeons, England: F. U. Anderson, M.D., and N. E. Mackay, M.D., Halifax, N. S., and A. S. Kendall, M.D., Sydney, N. S.

THE ONTARIO MEDICAL LIBEL CASE.—In the

case of *Lennox vs. McCammon*, referred to in our last issue, the judge's ruling was sustained by the higher court, and the verdict for the defendant fully confirmed. The issue in this case cannot but be gratifying to the members of the Ontario Medical Council and the profession generally.

CORONERS.—Dr. G. E. Coulthard, of Fredericton, has been appointed coroner for the County of York, N. B. Dr. W. J. Charlton, of Weston, has been appointed coroner for the County of York, Ont. Dr. J. D. Ross, of Moncton, has been appointed coroner for the County of Westmoreland, N. B.

OMISSION.—The name of Dr. Thom, councillor for Streetsville, was accidentally omitted in our last issue; also Dr. Bucke, of Palermo, and Dr. McLay, of Woodstock, Ont. Dr. Faulkner, of Stirling, has been elected warden of the county of Hastings.

As we go to press we learn with deep regret of the death of Dr. C. H. Lavell, eldest son of Dr. M. Lavell, of Kingston. We have also received an obituary notice of the death of Dr. J. R. Smith, of Harrowsmith, written by his former fellow-student, Dr. Dupuis, of Kingston. It will appear in our next issue.

A LONDON doctor was sent for by a lady in Chelsea. The lady apologized for asking the doctor to come such a distance, when the doctor unguardedly said: "Don't speak of it. I happened to have another patient in the neighborhood, and can thus *kill two birds with one stone*."

DR. WILLIARD PARKER is eighty-three years old; Alonza Clark, eighty; A. C. Post, seventy-seven; Isaac E. Taylor and Austin Flint, seventy one, and Frank H. Hamilton, seventy. Some of these distinguished medical men are still in active practice, notwithstanding their great age.

SIR BENJAMIN BRODIE'S PRESCRIPTION FOR GOUT.—R. Pil. hydrargyri, ext. rhei, ext. coloc. co. aa ʒj; ext. colchici acet., gr. xv. Ft. pil. xv. Sumantur tres horæ somni pro re natâ.

Prof. Balfour, Dean of the Medical Faculty of the University of Edinburgh, died recently at the age of seventy-five.

Books and Pamphlets.

A SYSTEM OF ORAL SURGERY, being a treatise on the diseases and surgery of the Mouth, Jaws, Face, Teeth, etc., by James E. Garretson, M.D., Dean, Philadelphia Dental College, etc. Fourth edition, revised and illustrated, pp. 1002. Philadelphia: J. B. Lippincott & Co.; Toronto: Hart & Co.

The work is well written, full and complete, both in description and illustration. Although a large portion of the book is taken up with dentistry proper, ample justice is done to the various surgical diseases and malformations of the face, nose, mouth and palate, and the operations for removal of the tongue, upper and lower jaw, etc., etc. The author has spared neither labor nor expense to render the work a complete and comprehensive exponent of oral surgery. It is supplied with a copious index. We heartily commend it to the attention of the profession in Canada.

THE STUDENT'S HAND-BOOK OF CHEMISTRY, with tables and chemical calculations. By H. L. Greville, F.I.C., F.C.S., chemist, London, Eng. E. & S. Livingstone, publishers, Edinburgh.

The author has endeavored to simplify the subject of chemistry as much as possible. The work deals with both inorganic and organic chemistry, and much information has been compressed into small compass. It is well adapted as a hand-book for medical students, being furnished with a copious index, and the text given in such a form as will render it readily accessible to the student. We commend the work to the attention of Canadian students.

A HAND-BOOK OF SKIN DISEASES AND THEIR TREATMENT. By John R. Kippax, M.D., L.L.B., Professor of Principles and Practice of Medicine and Medical Jurisprudence in the Chicago Medical College, etc. Second edition, revised, enlarged, and illustrated. Chicago: Duncan Bros. 1884.

We noticed at some length the first edition of this work, and would here add that the present edition has been carefully revised, many parts rewritten, illustrations added, and the book considerably enlarged. The work is essentially a digest of practical dermatology. It gives in small compass the classification, etiology, symptomatology, diagnosis, and treatment (Homœopathic) of cutaneous diseases.

THE EDINBURGH MEDICAL SCHOOL GUIDE TO STUDENTS, 1883-84. E. & S. Livingstone, publishers, Edinburgh.

This little work contains all the information required for graduation in medicine and sanitary science, also for the Licenses of the Colleges of Physicians and Surgeons. It also contains the examination questions, set by the University and Colleges, for several years past.

The International Review of Medical and Surgical Technics (quarterly), edited by Dr. J. H. Warren and others of Boston, is a new adventure destined to fill a useful place in medical journalism. The price is \$2 per annum. It is devoted to the illustration and description of new instruments, appliances, and methods of operation.

INGROWING NAILS.—The following practical hints on the management of ingrowing nails are from the Journal of Cutaneous Diseases.

When the nail threatens to grow into the skin, or has already injured it, the first indication is to put on a sock of moderate size and to remain quiet. Afterwards the nail is to be scraped on the affected side till it is sufficiently thin; then it is to be seized with a delicate forceps, raising it in a sense inversely to its natural curvature. This having been done a small lamina of lead of a few millimeters' thickness is to be inserted beneath the nail, and after folding it over the toe, it is to be fastened there with a strip of plaster. In this manner the granulation being no longer in contact with the margin of the nail, the pain ceases, and the sore heals more or less rapidly; during the whole of this time the apparatus should be frequently inspected, so that the lamina of lead may not become displaced. Besides this it is necessary to scrape the nail every two or three days, so as to keep it thin and flexible, until the skin returns to its natural state, and can resist the pressure of the nail, and then the lead is removed. Hebra treats ingrowing nails in the following manner: Cut some flakes of lint of the length of the lateral groove of the nail, or a little longer. The lint is to be placed under the nail parallel to the groove; then with a flat probe introduce the lint, thread by thread, between the flesh and nail. The parts are separated, with the little cushions of lint lying between. The sulcus is then to be filled with pledgets of lint, and finally long narrow strips of adhesive plaster are to be applied, always from above the inflamed sulcus downward, in such a manner that the latter is still farther removed from the margin of the nail. With such a dressing applied with sufficient care, there is no pain whatever; and

the patient can in a short time put on his ordinary stocking, and walk without trouble. After twenty-four hours the strips of adhesive plaster are to be removed, being previously softened in a bath of tepid water. This dressing is to be repeated daily; and in from two to four weeks it will be found that the toe is entirely well.—*Medical Age*.

SMALL DOSES.—The *Medical Times* and *Gazette* contains an article by Dr. J. C. Thorwood, in which he states the doses of medicines as set forth in books are often needlessly large when a gradual alterative or specific action from the remedy is desired. Calomel and other preparations of mercury, given in repeated small doses, in his experience, have proved valuable in the treatment of peritonitis, pleurisy pericarditis. He gives an example: A lady with knees drawn up in bed, rapid small pulse, black tongue and incessant vomiting. She had been confined about five days previous, and was taking repeated doses of opium. The opium was withdrawn and calomel administered in one-third grain doses every two hours. Under this treatment the vomiting ceased and convalescence set in.

The dose of tincture of aconite is from five to fifteen minims (British Pharmacopœia) but better results have been obtained from a dose of one or two minims every two hours in commencing inflammation.

The writer knows of no drug so generally useful in the treatment of asthma as arsenic, and in fifteen years' experience has seen a great many cases of spasmodic asthma that seemed to get quite well under the influence of small doses of arsenic. He never exceeded the dose of three minims of either Fowler's solution or of liquor sodæ arseniatis three times in the day.

In his hands excellent results have been obtained from a persevering use of very small doses (one-fiftieth of a grain) of strychnia in promoting the restoration of exhausted nerve function, while larger doses do but add irritation and eventually increase the exhaustion. Tincture of nux vomica taken in doses of one to two minims, fasting every morning, is very useful in the cure of chronic constipation of the bowels while five or ten minim doses three times daily act very much like quinine in checking the action of the liver, and causing disturbance of the system.—*New Summary*.

ON SCHOOL HYGIENE.—This was the subject of an address before the American Health Association, at its last meeting, by Dr. Charles J. Lundy, of Detroit. He sums up tersely as follows what is required to remedy existing defects:

1. Avoid the cramming process in education, and the nervous excitement due to the spirit of rivalry.

2. Reduce the number of subjects in the curriculum, and shorten the periods of study.
3. Ventilate the school rooms in accordance with the most approved methods.
4. Regulate the temperature of the school-room—an atmosphere which is too warm debilitates the system.
5. Provide properly constructed and arranged seats and desks.
6. Instruct pupils to sit erect, and to hold the book or paper at least twelve inches from the eye.
7. Provide highly myopic pupils with proper spectacles, which will enable them to read at the natural distance of twelve inches.
8. Furnish pupils with well-printed books.
9. Furnish abundance of light, without producing glare. Let it come from the left side if the room is narrow, from both sides if the room is wide.
10. Provide for the physical education of school children, and teach them the importance of outdoor exercise.

PROF. BARTHOLOW says iodide of ethyl is a very valuable antispasmodic, singularly, and immediate beneficial in spasmodic asthma, also lessening liability to subsequent attacks. In capillary bronchitis it is conspicuously beneficial, as also in catarrhal pneumonia. In chronic bronchitis it is a most valuable agent, from its local action. It will probably take the place of iodine vapor for respiratory diseases. The dose is gr. v-xx three or four times a day, by inhalation, generally from a handkerchief.—*Coll and Clin Record*.

FOR TORPIDITY OF THE LIVER.—Professor Delafield, of New York, recommends the following :

R	Podophyllin.,	grs. ij,
	Hydrarg. bichlorid.,	gr. j,
	Pulv. ipecac.,	grs. iv,
	Ext. colocynth co.,	grs. x. M.
Ft. pil. No. xx.		
Sig. One pill three times a day.		

PAINLESS PARACENTESIS.—Since general etherization is sometimes interdicted owing to some heart trouble, etc., and since the ether-spray is disagreeable, owing to the odor of the ether, the following, not very new, but practical suggestion of Dr. F. P. Stapes in the *Brit. Med. Jour.*, Nov. 17, '83, is worthy of note. He applies a mixture of salt and ice for about twenty minutes before the operation. This completely destroys all sensibility in the part.—*Med. and Surg. Reporter*.

ETHER IN TYPHOID FEVER.—A French physician considers hypodermic injections of ether very

valuable in the adynamic forms of the disease. He reports five cases so treated. Two injections, of twenty drops each time, were made daily, and under its influence the patient was aroused and delirium ceased. In pneumonia, these injections are of the greatest utility, as they are in every malady assuming a typhoid form.—*Med. and Surg. Reporter*.

At the clinic (*Col. and Clin. Record*) Prof. Pen-coast's wrist tourniquet is used by him. It consists of two compresses over the ulnar and radial arteries, covered by a strip of adhesive plaster extending almost around the wrist. He reported an operation in which the palmar arch was cut, and hemorrhage was prevented by this tourniquet alone, no ligatures being used.

NEURALGIA.—Prof. Roberts Bartholow recommends equal parts of chloroform, camphor and hydrate of chloral, as an efficient local application to allay the pain of neuralgia. This simple mixture, he recently stated to his class, is very rapid in its anodyne action on the part to which it is applied.—*Med. Summary*.

PROF. PARVIN says that a strict milk diet is the best and almost certain remedy for the albuminuria of pregnancy. A recent case thus treated was delivered of twins, no convulsions occurring.—*Coll and Clin Record*.

Prof. Rogers, last week, demonstrated the folly of decolorizing solutions of iodine, the reaction being really the formation of an iodide and iodate.

Births, Marriages and Deaths.

On the 23rd ult., the wife of Dr. J. Fulton, Toronto, of a daughter.

At Chatham, N. B., on the 13th ult., John Thomson, Esq., M.D., aged 75 years.

At Whitevale, Ont., on the 4th ult., J. R. Tabor, M.D., aged 43 years.

In Chicago, on the 26th of January, Alexander C. Savage, M.D., formerly of Ottawa.

At Harrowsmith, Ont., on the 17th ult., Dr. J. R. Smith, aged 45 years.

In Kingston, on the 26th ult., Dr. C. H. Lavell, eldest son of Dr. M. Lavell.

* * * The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forward in postage stamps with the communication.

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Original Communications.

CONCUSSION OF THE SPINE.*

BY A. WORTHINGTON, M.D., CLINTON, ONT.

Perhaps this subject will be best considered and present an amount of interest equal to any other, by taking up "Concussion of the Spine," the pathology of which presents such varied and remarkable features. Mr. Robert Liston has said that "no injury of the head is too trivial to be despised," and Mr. J. E. Erichsen says in his lectures on "Injuries of the Nervous System," p. 84, the "observation, true as it is with regard to the head, applies even with greater force to the spine." Few clinical details are to be found in works on surgery, and there is not an abundance of clinical writing on this subject by specialists. Three classes of injuries are mentioned by Mr. Erichsen. 1st. Concussion of the spine from direct and severe injury. 2nd. Concussion of the spine from slight injuries, concussion from carriage accidents and from falls and shock. 3rd. The effects produced by wrenches or twists of the spine. The following case will illustrate the first class:—J. R., a clerk by occupation, was admitted under the care of Mr. Erichsen, into University College Hospital, October 2nd, 1862. He had been knocked down half an hour previously by a cab, the horse's knee striking him on the neck. He was conscious, but quite unable to move, and passed his urine and fæces involuntarily on his way to the hospital. There was abrasion and ecchymosis on the left side of the neck. There was no irregularity or inequality of the spinous processes or evidence of fracture. There was also complete paralysis of sensation and motion from the shoulders down. The breathing was wholly diaphragmatic. He

complained of great pain at the point of injury, and in the right hand and arm which was bruised. Motor power not entirely lost, as he could raise his legs and cross them, but sensation is entirely gone. His great distress was a feeling of tightness as of a cord tied tightly round the abdomen below the umbilicus. 5th October, had slept well, pulse 64, strong; passes fæces involuntarily. 8th. Is able to move his head and neck from side to side; has less pain; urine has been ammoniacal from the beginning; bedsores over sacrum have much extended. 10th. Difficulty of breathing came on, but was relieved by the 11th. On the 12th it returned with mucous râles, and he died that night, ten days after the accident.

Autopsy.—The brain was found uninjured and healthy; the 6th and 7th cervical vertebræ had been separated posteriorly; the vertebræ themselves and their arches were quite sound, but there was a fissure extending through the articulating processes on the left side, without displacement. A large quantity of blood was extravasated into the spinal canal lying between the bones and the dura mater, also a quantity of reddish brown serum in the arachnoid. The pia mater had some blood patches on it in the lower cervical region. The cord itself was quite healthy.

Boyer* relates two cases. In one the patient struck his loins by falling into a deep ditch. He was affected by complete paraplegia, and speedily died. On examination no morbid appearances could be detected; neither fracture, dislocation, effusion or any lesion of the cord or its membranes. In the other case, a man amusing himself with gymnastic exercises, strained his back between the shoulders. He became paraplegic and died in a few weeks. After death no lesion of any kind was found in the spine or cord.

Twists or wrenches of the spine without fracture or dislocation of the vertebræ are among the most serious affections of the spinal cord which are met with in surgical practice. In all the various forms and degrees of injury sustained by the spinal column, some or all of the same train of symptoms follow soon or later. If immediate or secondary the countenance is usually pallid and has a careworn anxious expression. The memory is defective; the thoughts are confused; all business

*From the report on Surgery and Surgical Pathology of Diseases of the Nervous System, read before the Ontario Medical Association, in June last.

* Maladies chirurgicales, p. 135 and J. E. Erichsen's Lectures, p. 28.

aptitude is lost, temper changed, and sleep is restless and broken. The organs of special sense are often more or less seriously affected, and the state of the spine will be found to be the cause of all these symptoms. The lesions when found are : 1st. Hemorrhage† within the spinal cord. 2nd. Laceration of the membranes of the cord and extravasation of the medullary substance. 3rd. Disintegration, and perhaps effusion and inflammatory softening of the cord. Hemorrhage of the spinal canal may occur. 1st. Between the vertebræ and dura mater. 2nd. Between the membranes and the cord. 3rd. In both situations.

Diagnosis.—There appear to be three morbid conditions for which concussion of the spine may be mistaken. They are :—1st. The secondary consequences of cerebral concussion. 2nd. Rheumatism. 3rd. Hysteria.

Prognosis.—"Concussion of the spine may prove fatal, first, at an early period, from the severity of the injury ; secondly, at a more remote date, from inflammation of the cord and its membranes ; and thirdly, after the lapse of several years, from the slow, certain and progressive structural changes in the cord and its membranes," due probably to inflammatory action of a very chronic character. As to recovery, two points are noticed. "First, the recovery from the primary and direct effects of the injury, and secondly, from the secondary and remote consequences of it." Recovery is said to take place more often and complete in concussion of the spine in the primary stage, and before the secondary stage is reached. This will apply more especially to young and healthy persons. "Ollivier makes the statement that it is rare to find inflammation of the spinal membranes limited to the vertebral canal, that we find at the same time a more or less intense cerebral meningitis, that they often complicate the case so as to render the diagnosis difficult, especially in the early stages." Partial recovery is not unusual in cases of severe and direct injury to the spine. Recovery up to a certain point takes place and remains stationary, beyond which they rarely get, as it is probable that structural lesions have taken place in the membranes if not in the cord. Erichsen says, (page 100), "I have never known a patient to recover completely and entirely so as to be in the same state

of health that he enjoyed before the accident, in whom the symptoms dependent on chronic inflammation of the cord and its membranes, and on their consecutive structural lesions had existed for twelve months ; and Ollivier has observed that while such a patient may live fifteen or twenty years in a broken state of health, the probability is that he will die within three or four.

Treatment.—There is not much to be said in reference to treatment. Absolute rest in the prone position is of the utmost importance. This places the spine as the highest part of the body and pressure upon the injured parts is avoided, passive congestion prevented, and possibly bed-sores from loss of vitality, and what is of equal if not greater importance, after symptoms of shock have disappeared, the persistent and cautious application of cold water over the injured part, or any portion of the spine which is tender and painful. Blisters may also be applied with good effect in conjunction with cold water, or ice, if necessary.

...

NOTES ON THE TREATMENT OF LUPUS

BY J. GUN, M.D., DURHAM, ONT.

I have recently had the opportunity of trying Volkmann's process of "Evidement" in the treatment of three cases of Lupus, a report of which may not be uninteresting to some of the readers of the LANCET.

CASE I. Lupus Serpiginosus.—A middle aged lady, multipara, complained of an obstinate disease of the skin of the face, which had troubled her for years. She enjoyed perfect health otherwise ; her children also were robust, and free from any skin or glandular affections. On examining the face, I found the skin over the malar bone of the left side, as well as that over the inferior border of the orbit, paler than the surrounding integument, glistening, thin, and slightly depressed. A number of tubercles of the size of peas, some isolated, some confluent, and in part covered with crusts of a dirty yellow color, occupied the side of the nose of the same side. On removing the crusts, the granulations were of a livid red color, soft, friable, bleeding easily, and, on pressure, exuded a thin pus. The treatment consisted in the free application of a pointed stick of nitrate of silver to the diseased surface. By this means the granulations were easily

† Erichsen's Lectures, p. 38.

removed and at the same time the lupoid nests destroyed. In a few weeks the progress of the disease was effectually stopped, a pale, glistening cicatrix alone marking the site of the lupoid granulations. This lady removed to a distant part of the Province, so that I have not had an opportunity of knowing whether there has been any re-appearance of the disease.

CASE II. *Lupus Vulgaris*.—The left cheek over the buccinator muscle was occupied with a circular patch of lupus tubercles fully two inches in diameter, the skin towards the ear being of a glistening and scar-like appearance. The tubercles were closely packed together, raised one to two lines above the surrounding skin (*lupus exuberans*), of a livid red color, firm to the touch, slightly painful, bleeding easily, and, on pressure, exuding a cheesy-like pus. In this case, a healthy subject otherwise, a male, of middle age, the disease had existed for many years. It first shewed itself in front of the pinna of the ear in the form of small, pointed tubercles, at first isolated, but soon becoming confluent and covered with crusts. Fresh tubercles formed, advancing towards the angle of the mouth, and as these matured, the older exfoliated and disappeared, leaving the skin of a glistening appearance, thinned, depressed and bald. The treatment at first adopted was by caustics. Vienna paste, chloride of zinc, pernitrate of mercury, etc., tried in succession, but without making any decided impression in the removal of the diseased mass. Latterly I adopted Volkmann's plan which proved successful. The tubercles were removed one by one with the scoop end of an ordinary director, and after bleeding had ceased, a pointed stick of nitrate of silver was pressed with a boring motion into the depths of the lupus nests in the tissue of the corium. In a week or two a few fresh tubercles made their appearance on the raw surface here and there, and especially along the margins of the ulcer, but these were easily removed by a fresh application of the nitrate of silver. Cicatrization went on rapidly, and now, twelve months after all treatment ceased, there has been no return of the disease.

CASE III. *Lupus Exulcerans*.—When this case came under treatment it had advanced to the stage of ulceration. The lupoid ulcer was situated on the upper lip, near the base of the right nostril and immediately over the root of the canine tooth. The

base of the ulcer was covered with red granulations, painful and bleeding easily, the margins being well defined, firm and undermined. External to the ulcer there were several tubercles, discrete, of the size of small shot and of a yellowish red color. The granulations were removed in the usual way, after which a few applications of the nitrate of silver in stick was made to the base and sides of the ulcer. The progress of the case is satisfactory. It is still under treatment, but from the healthy granulations formed in the base of the ulcer, and the rapid closing in of the margins with healthy tissue, it is evident that the disease has been removed and that the cure is nearly complete.

In these cases the treatment adopted has been essentially that recommended by Volkmann in 1870. As is clearly stated by that distinguished authority, the treatment of lupus resolves itself into two steps: first, the removal of those tissues which are so affected that healthy permanent tissue cannot be formed from them; secondly, the destruction of the young lupoid cells. The first object may be secured, in some cases no doubt, by the use of caustics, but, as Volkmann recommends, and as my experience, though limited, has confirmed, it will be much more easily and effectively attained by the use of the scoop. For the destruction of the lupoid nests, or as Volkmann has it, the absorption of the lupoid cellular infiltration, he recommends multiple punctiform scarification with a narrow-bladed knife. I tried this method in case No. 2, but found that boring into the lupoid nests with a nitrate of silver stick was preferable. It penetrates the lupus tissue easily, but meets with considerable resistance when pressed against tissue free from the disease. It would seem, however, that in large confluent lupus in which the corium is extensively infiltrated, punctiform scarification, often repeated, would be attended by good results.

Lupus being a local disease, no special constitutional treatment was adopted in these cases, except such as was indicated by the general condition of the patients.

Correspondence.

EMPHYSEMA DURING LABOR.

To the Editor of the CANADA LANCET.

SIR,—On the 26th of February I was summoned to attend Mrs. D., æt. 21, in her first confinement.

On arriving, I found the pains recurring about every fifteen minutes and expulsive in character. The os was the size of a dollar and head presenting in the first position. Labor progressed favorably during the subsequent hour and a half, when I observed my patient's face very much swollen, the swelling appearing suddenly. The child's head at this time, twenty minutes before delivery, was forcing my hand on the perineum and required my undivided attention. I merely ordered the neck-band of the night-dress loosened, and immediately after the child was born I examined the patient and found the following condition: The swelling extended from the anterior border of the trapezius muscle on one side to the same position on the opposite, causing the neck to be nearly even with the chin, and vertically from both malar bones downwards to a level with the third or fourth ribs. The skin was normal in appearance, swallowing and breathing were performed with ease, the patient was cheerful and exceptionally well in every respect. On applying my fingers to the swelling, I could feel the peculiar crackling sensation characteristic of emphysema. In fact the patient could distinctly hear it when moving her jaws. This crackling sensation could be distinctly felt over the entire surface of the swelling, but more especially evident in front of the neck, on both sides of the larynx and trachea. I left the case entirely to nature, ordering no special treatment.

On the 27th I visited my patient and found her in about the same state. She had slept well all night, had an excellent appetite, and was very comfortable; the swelling had slightly diminished. This was the first time, in an obstetric experience of nearly 2000 cases, that I had seen a case of the kind. There is no doubt that the air became extravasated into the cellular tissue during the straining of the patient in order to assist nature, although the straining did not appear more than usual, in fact not nearly so severe as I have seen.

I think the case is of sufficient importance to enable us to see in it another danger of advising patients to strain and hold their breath in order to accelerate delivery, a custom very commonly adopted by midwives and nurses, and one that cannot be too strongly condemned. In all ordinary cases, nature asks for all necessary aid by causing involuntary muscular action, rendering voluntary action not only unnecessary but dangerous.

Yours, etc.,

J. S. BENSON, M.R.C.S.E.
Chatham, N.B., 28th Feb., 1884.

JOHN R. SMITH, M.D., HARROWSMITH, ONT.

To the Editor of the CANADA LANCET.

SIR,—When a member of our profession dies, the least we can do in the way of respect for his memory is to honor him with an obituary notice. In our profession, honors do not crowd "thick and fast" upon any of its members; there are no salaried sinecures to which we can look for an appointment; there are no hopes of being pensioned off with a comfortable living when age has stiffened the limbs and dulled the faculties, or when overwork has forestalled the ruthless hand of time. The hard and honest toilers amidst disease and death, who in the darkness and the daylight, through summer's heat and winter's cold, never refuse to face all weathers, and who, in the rude cabins of the humble as well as in the more comfortable abodes of the well-to-do, labor on, and worry, and wear themselves with suffering, that others may suffer less; have no peculiar social privileges or public distinctions. Wealth is a prize that few if any can ever attain, and the "otium cum dignitate" that is often the dream of youth, flies before them, as the rainbow that covered the cup of gold, fled from its pursuer. For the vast majority of medical men the song must be:

Labor on, labor on! there'll be resting by and bye,
When life's short day is done, and head and hands shall lie
Where the tomb its quiet shelter o'er us throws,
And no waking ever breaks our long repose."

Dr. Smith was one of the toilers who labored on, and labored more than others might suffer less, and who looked for no greater testimonial to his worth than the plaudit of "Well done, faithful servant," and no monument more honorable than a memorial thought deeply engraved upon each of the many hearts from which he had lifted the burden of sorrow. He was born at Ormiston, in Scotland, in the year 1831, and in his youth came thence with his parents to Kingston, Ont. Of his early life I know nothing, having first become acquainted with him during my college days at good old Queen's University in this city. For several years past I have been acquainted with various members of his family and they belong to that class of persons whom to know is to love; they are true representatives of that type of "Auld Scotia's" sons, who look upon an honest man as the noblest work of God. In 1863 he graduated

in medicine, and immediately after his graduation went to the United States and joined the army of the Republic as assistant surgeon of volunteers. He acted in this capacity until the close of the war in the fall of 1864, and thus for a year and a half obtained the surgical experience which only a great war can afford. Upon his return to Canada, partly through my advice and partly through the advice of other friends, he settled in Harrowsmith, which although a small village at that time, afforded one of the best country practices in this part of Ontario. There his professional ability, his urbanity, his goodness of heart and his geniality of disposition soon became known, and established him not only as one of the leading medical advisers in that section of country, but as a pleasant companion and a true family friend. When our Canadian volunteer militia was organized, Dr. Smith was appointed Surgeon of the 47th Frontenac Battalion, a position which he vacated only at his death. Although of more than average professional ability, he was content to fill his calling in a hard country practice, rather than cultivate an easier life in some large town or city. Although frequently speaking of adopting the latter course, the feeling of attachment between his country patients and himself was so great that he could never fully make up his mind to sever the links that bound them together.

For the past twenty years Dr. Smith has been a useful man to a large and increasing number of clients, and now that he has gone, hundreds feel that they have been bereft of a friend, and mourn his untimely loss. He possessed a good constitution, and seemed to enjoy the best of health up to about six months ago. He then began to complain of more or less pain behind the sternum, of an occasional dry irritative cough and difficulty in swallowing; he began also to lose flesh and suffer a deterioration of muscular strength. He continued to perform his professional duties, however, and on several occasions of my meeting with him he stated his condition to me, but supposed he was suffering from bronchitis and that he would soon recover. About three months ago I was called to see him, and from the symptoms then manifested I diagnosed cancer of the stomach with obstruction of the œsophagus. My partner, Dr. Henderson, saw him some time afterwards and confirmed my opinion, which was also concurred in by Dr. Day, of Harrowsmith. We continued to visit him occa-

sionally, Dr. Day especially giving him every care and assistance in his power, until death brought him his final release from suffering.

The day after his decease, Drs. Day, Henderson and myself made a post-mortem examination, and found abundant confirmation of our diagnosis. A large cancerous mass, in a stage of ulceration, occupied the lower part of the œsophagus, and several hard nodules, one of them as large as a pullet's egg, were situated in the walls of the stomach about the cardiac orifice, and some of these also in the ulcerative stage. Other abdominal organs also were affected. For eight weeks previous to death he was confined to his bed, and although his sufferings were very great, never a murmur or complaint escaped his lips. He leaves a kind and devoted wife to mourn his loss, but no children.

Thus has passed away a noble-hearted and useful professional brother at an age when experience should have crowned him with distinction in his chosen vocation. In his death I miss another of the remaining few that sat in the class-rooms with me and drank in knowledge from the same teachers. Thus I am reminded that one by one the links are breaking that enchain our spirits here, and that ere long I too must follow, and that the generation even to which we belonged shall soon be numbered with the past.

Yours truly, THOS. R. DUPUIS.
Kingston, Ont.

NOVEL INHALER.

To the Editor of the CANADA LANCET.

SIR,—I had occasion to give chloroform a short time ago where I was dubious as to using the napkin, as the patient was suffering from rheumatic valvular disease, and as I was wearing matted cuff-protectors worn by storekeepers, the idea suggested itself to cover the small end with lint and drop the chloroform thereon, and by stretching or compressing I could regulate the quantity of air I desired mixed with the chloroform vapor. The experiment was so successful that I have used the cuff-protector several times, and am convinced that it is as good a means of administering anæsthetics as can be got, and the expense is *nil*.

Yours faithfully,
JAMES SKIRVING.
Tavistock, Ont., Feb. 23, '84.

Reports of Societies.

SANITARY CONVENTION.

The Ontario Board of Health held its second annual sanitary convention in Ottawa on the 12th and 13th ult. The attendance was very good, and many interesting papers on sanitary matters were read and discussed. The chair was taken by Dr. Sweetland and the association was welcomed by the mayor. An introductory address was delivered by the chairman of the Board, in which he dwelt chiefly upon sanitary statistics, the reduction in the death rate in consequence of sanitary improvement in recent times; and concluded by defining the respective duties of the Dominion and Local Parliaments, and municipalities, in regard to sanitation.

In the afternoon session, Dr. Canniff, medical health officer for Toronto, gave an interesting account of his labors in sanitary work in the Queen City of the West, and quoted from his report recently published. In his work he was assisted by a staff of policemen, and these were instructed to visit every house and examine the drainage, disposal of sewage, condition of water closets, yards, lanes, &c., and suggest changes and improvements. Legal proceedings were in every case avoided, so as not to array the public against the system. In the discussion which followed, Dr. Canniff's plan was strongly approved. An address on "The Ventilation of Dwellings," by Prof. Bap-tie, Ottawa, and a paper by Dr. Cassidy, Toronto, on "The Ventilation of Public Buildings," evoked a very interesting discussion.

At the evening session Dr. Covernton, of Toronto, read a paper on the "Abuse of alcohol, and increase of nervous diseases in modern times." He said that by the abuse of alcohol men were led to a premature death after the destruction of body and mind, and gave some startling statistics to that effect. The greater part of alcoholic drinks offered for public sale contained more or less of the poisonous kinds of alcohol, and he approved of the Government encouraging the importation of light, cheap wines by low duties. A paper on "School Hygiene" was read by S. Woods, Ottawa, who was in favour of cheerful school-houses, and plenty of exercise for pupils. He considered that overwork and overstudy were not so injurious as the want of

hygienic arrangements. Dr. Bryce, Toronto, read a paper entitled "Zymotic diseases, where they are, and why," and illustrated his remarks with magic lantern diagrams.

On the second day a paper was read by Dr. E. Playter, of Ottawa, on "Diet." The points which gave rise to most discussion were the expression of the opinion that cancer was on the increase in Ontario, and an account of some experiments showing that the human system is better able to resist catching cold under low than full diet. The question was raised whether the greater accuracy of vital statistics did not cause apparent increase. Dr. Playter, however, appeared to think the increase was real. Rev. Mr. Wood asked whether the old adage "Feed a cold and starve a fever" was sound or ironical. Dr. Playter, Dr. Small, and Dr. Sweetland all agreed that the best policy was to 'starve' a cold. Dr. Small said the true reading of the maxim was, "If you feed a cold you will have to starve a fever."

T. Guerin, C. E., Ottawa, read a paper on "Sewerage," in which he criticised the various means of ventilating sewers by man-holes or shafts. He condemned all these plans except ventilating by man-holes, which he considered the least objectionable. In summing up the different modes of ventilation, he concluded that no treatment of sewer gas was so good as cutting it off altogether, trapping it at every possible point. He entered into a discussion of the various kinds of traps, and exhibited a model of one which he considered most efficient.

The question of establishing a Dominion Board of Health next came up for consideration, and after considerable discussion it was decided to defer further consideration of this matter until after the next meeting of the Canada Medical Association in order to give the Committee of that body time to report. F. N. Boxer, C.E., Montreal, read a paper on the "Hidden Sources of Disease," such as defective sewers, bad water, impure air, &c., and urged the claim of sanitary science on the assistance of the government. Dr. Rogers, of Ottawa, followed, with a paper on the "Prevention of Disease," in the course of which he strongly objected to the placarding of houses where infectious diseases existed as a tendency to excite alarm. Dr. Covernton replied, showing the benefits of placarding in staying the spread of infection.

At the close of the meeting resolutions were adopted expressing the opinion that local boards of health should have power to enforce the proper drainage of houses, and declaring that persons suffering from or recently recovered from infectious disease should not enter public conveyances.

ONTARIO BOARD OF HEALTH.

First regular meeting of the Board for the present year was held in Toronto on the 6th, 7th and 8th of February, 1884. Members present Drs. Oldright, Covernton, Cassidy, Rae, Yeomans, Prof. Galbraith, and Dr. Bryce, Secretary. The minutes of the last meeting were read and confirmed, and various communications read. Amongst these were letters from Dr. Powel, of Edgar, *re* small-pox; Dr. Wells, of Barrie, *re* diphtheria; F. G. Johnston, Sarnia, *re* methods of obtaining reports, and others. The report of the Legislation Committee was then taken up.

February 7th—After routine the chairman read a communication from the Minister of Education in reference to the preparation of a work on school hygiene, after which it was moved by Dr. Cassidy, seconded by Dr. Covernton, and carried,—That a Special Committee composed of Drs. Oldright, Covernton, Cassidy, Yeomans and Rae, be appointed to prepare a work on hygiene.

The report of the Committee on Legislation was received and adopted. The subsidy to the *Sanitary Journal* was, on motion, continued to the end of the year ending August, 1884.

February 8th—After routine, a communication from Mr. Allan McDougall was received *re* extending the course of sanitary lectures. After discussion it was moved by Dr. Rae, and seconded by Dr. Yeomans and carried—"That a sum not exceeding fifty dollars be devoted to the purpose of defraying the expense connected with a partial course of additional lectures on Sanitary subjects in connection with the Canadian Institute, if the proposition meet with the approval of the latter body."

In the matter of continuing the weekly disease reports it was directed that the Publication Committee be requested to consider and report upon the best means of curtailing the expenses connected with the publication of the weekly Health Bulletin.

The matter of the Ottawa Convention was then discussed, and various matters of arrangement completed, after which Dr. Yeomans read the report of the commission to investigate typhoid fever in Luther Village, which was adopted.

Selected Articles.

THE DIAGNOSIS OF ABDOMINAL TUMORS—VESICO-VAGINAL FISTULA.

CLINIC—BY W. GOODELL, M.D., PHILADELPHIA.

The first case I bring before you is a perplexing one, and I bring it before you for the purpose of diagnosis. I have already examined the case with a great deal of care, but I am in great doubt as to its nature. It shows the difficulty in the diagnosis of abdominal tumors. If I cannot, with all my experience, tell what the matter is; how much more likely will you be to blunder? The first peculiarity about this case is that the lady has a very good complexion; her lips and tongue are of good color. She has a far better appearance than you ordinarily see in abdominal tumors. She says that four years ago, she detected a swelling in the abdomen. I do not place much reliance upon these statements made by patients. Women often come to me thinking that they have a tumor, and on examination I find nothing but wind. If she had said that her physician had found the tumor, I should have placed more confidence in the statement.

This is a puzzling case, because I cannot make out whether this is a cyst or whether it is free fluid in the abdominal cavity. If it were free fluid, it would constitute abdominal dropsy, and we should naturally expect to find some cause for the dropsy. I have examined the heart and lungs carefully, but they are perfectly healthy. There is no disease of the liver, although I at first thought I detected some signs of hepatic trouble. I next turned to the urine; specific gravity, 1022; alkaline reaction, no sugar or albumen. In the sediment there are triple phosphates and a few octahedral crystals of oxalate of lime. There is then no evidence of organic disease of the kidneys.

Examining the tumor, you see that it does not project as cysts usually do. It is flaccid, and on percussion you can see the wave pass from one side to the other. In the cysts that you have seen, the tumor has been tense and projecting, but here we have a tumor irregular in shape, flaccid and bulging laterally. The appearances are those of free fluid in the abdominal cavity.

If this were abdominal dropsy, we should expect to find resonance on percussion in front from the floating up of the intestines. I now percuss, but

all over the front there is perfect dulness. I press deeply, but can develop no resonance. This is not a feature of ascites, but it might be due to great distension of the abdomen, which is not the case here, or it might be due to inflammatory adhesions preventing the intestines from floating upwards. Let us see if we can get the coronal resonance which is due to the intestines surrounding the cyst, giving a crown shaped resonance. On the right side there is no resonance. There is more over the stomach, but on the left side in the line of the descending colon I find some resonance. The intestines may be adherent at this point.

I have carefully examined the womb. It measures 3.5 inches. It was retroverted but I was able, with the sound to raise it and make such motion that I feel the greatest assurance, although not positive certainty, that the womb has nothing to do with the tumor, unless there should happen to be a fibroid tumor. A pedunculated fibroid tumor may produce dropsy of the abdomen, and the patient retain fair health, because it is a dropsy from irritation.

I tell you candidly, that I do not know what this is; but I am disposed to think that it is a cyst of the broad ligament. I shall tell you why. These cysts are more apt to be flaccid; they last longer, from four to nine years; they interfere with the general health less than any other tumor; they rarely give pain; and they have alternations of flaccidity and distension. I have examined this woman in different positions, but the result was always the same. I shall now tap her and see the character of the fluid. I first freeze the part with ice and salt and then plunge in the aspirating needle, and immediately the fluid begins to flow. I have taken care to see that the bladder had been emptied. This is a slow way to remove the liquid, but it is a safe way.

While the fluid is flowing, I shall talk a little about this object of tapping, because it is an operation which you will have to perform. It is not difficult to do, if you observe certain rules. Other things being equal, always tap in the linea alba, because there we find the fewest blood vessels. The point of election is midway between the umbilicus and the symphysis. If the most prominent point of the cyst is to one side, it will be proper to tap at that point. In the second place; use the aspirator in preference to the trocar. In the third place, and by the way, this should have been among the first, see that the bladder is empty. There are good reasons for this rule for the mistake of confounding a distended bladder with an ovarian cyst has often been made.

The danger from the use of the aspirator in ascites is very small, for the peritoneum has been so altered by pressure, that it is no longer so vulnerable as the peritoneum is usually considered to

be. There are greater dangers in tapping a cyst, for the wall of the cyst is vulnerable, and may have inflammation of the cyst followed by septicæmia. This has occurred in my hands. It is a good rule never to tap an ovarian cyst if you have decided to remove it, and the patient has consented. There are certain exceptions to this rule. If the cyst were so large that it pressed on the veins, giving rise to œdema of the extremities or œdema of the lungs, it would be proper under these circumstances to precede the operation by a tapping, so as to relieve those œdematous symptoms and put the woman in a better condition to bear the operation. If you have a polycyst, it is a good rule not to aspirate, for as the large cyst is filled with many smaller ones, there are blood vessels running in every direction and there is danger of wounding a blood vessel and of having internal hemorrhage. The bleeding may come from a vessel in the wall of the abdomen. If there is internal hemorrhage, which you determine by the ordinary symptoms, the best things to do are to include the point of puncture in a ligature, or to use an acupuncture needle, or to put in a hair-lip pin and throw around it a figure-of-eight ligature.

As I say, my rule is not to aspirate an ovarian cyst unless the patient insists upon it. A woman has a cystic degeneration of the ovary, she has heard of cases of recovery after tapping, and she insists upon having this tried. An interesting case occurred in the practice of a physician out west. A woman came to him with a large tumor which he diagnosed to be a cystic tumor, and told her that nothing would cure her but an operation. She had however heard of a notorious nostrum which cures everything under the sun, and began to take it. A day or two afterwards she met with an accident which ruptured the wall of the cyst, and she began to pass large quantities of water which she attributed to the use of the Panacea. The result was that the tumor disappeared for several months, but it soon refilled and the doctor had to remove it by operation.

I had a case two weeks ago which shows the danger of rupture of the cyst. A lady was brought to me by her husband and physician. From her appearance, I judged that she had a malignant tumor. She had excessive pain. She was very much emaciated and had taken opium in large doses. On examination I found two tumors in the abdomen, and my diagnosis was that both ovaries had undergone cystic degeneration. She had not been so far from home for a long time. The following day she was seized with violent pain, and when her physician came, he found her in a very alarming condition. She went from bad to worse, developed high inflammatory symptoms and died in a few days. Her physician wrote to me asking the cause of this inflammation. It was clearly due to a rupture of one cyst and the irritating fluid

getting into the cavity of the abdomen, produced a rapid peritonitis to which the patient succumbed. If a broad ligament bursts, there is not the same danger, for the fluid is more bland.

The fluid that is here escaping has not the appearance of that from a broad ligament cyst. In my experience such cysts contain a limpid, pearly colored fluid, sometimes having a greenish tinge. From the appearance of this fluid I should say that it came from an ovarian cyst, but before submitting her to an operation, for which she is prepared, it is my duty to have this fluid carefully examined. There is now some resonance over the stomach. You may ask "why can you not feel the cyst wall?" This cyst, as far as I can discover, is unilocular, and is so thin and collapsed that I cannot feel its wall.

I shall apply a strip of adhesive plaster over the puncture and keep her in bed for forty-eight hours. In cases of abdominal dropsy, I sometimes put on a binder, but as a rule I do not after tapping an ovarian cyst. If the abdomen is very flaccid and the woman feels more comfortable with the binder, I use it.

VESICO-VAGINAL FISTULA.

The next case is a very distressing one of a woman who, as the result of a several days labor, had a very bad vesico-vaginal fistula. She was attended by two good physicians. I have told you one thing over and over again, and I want to reiterate it. I say that there is a tendency in this age to use the forceps too frequently, and the results are laceration of the perineum and laceration of the neck of the womb. These two lesions are very frequently, although not always caused by the use of the forceps. When I come across a very bad tear of the perineum, I am very sure to find that it has been a forceps case. I say that when you graduate, you will not be skilful enough to deliver a woman safely all the way through with the forceps. You will turn the head out too quickly. I myself do not feel warranted in delivering a primipara all the way through with the forceps, unless it is absolutely called for. My rule is to bring the head down to the perineum, cause it to bulge, then take the forceps off, and allow nature to finish.

There are certain cases in which it is proper to put on the forceps, and that is where the head after it is engaged in the superior strait, does not descend. Under such circumstances, I should advise you as young men, to call in a brother physician to assist you, but when you live in the country, four or five miles from any other physician, you cannot do that. The country is a splendid school. It develops pluck and courage.

I have forgotten her history, so I shall ask a few questions. She says that this occurred nine years ago with her first child. She was three days and two nights in labor. That, however, does not

mean anything. She might be in labor a week in the membranes were unbroken, without receiving any harm. She does not know whether the water had come away or not, for she had convulsions. The head was impacted and the physicians had a great deal of trouble in delivering her with instruments. The child was dead. I do not know whether or not craniotomy was performed. The result was a great deal of sloughing and the formation of a vesico-vaginal fistula of large size. It had been operated on by a good physician but with poor results.

She came to me March 1st. The opening was then large enough to admit three fingers. There is one thing about these fistulæ which I do not think has been described, a frequent absence of menstruation. She had, in addition to the sloughing of the vagina, a tear of the perineum, and as a result there was found a very sensitive cicatrix. The trouble in operating was that we could not get her under ether. Although she would be snoring, yet as soon as the speculum pressed upon the cicatrix, she would straighten herself out. I have noticed this repeatedly in laceration of the perineum with some sloughing. I managed to close up the fistula, but I had to take out one stitch in order to pass a catheter. A week ago last Sunday, I operated to close the small opening, and I shall now remove the stitches. You see that she is quite fat, and I find that the worst cases of laceration occur in stout women.

I have removed the sutures and it looks as though it were a cure, but we shall have to wait a day or so to decide that. She will now be taken to her ward. The secret of success in operating on vesico-vaginal fistula is to denude the parts and coapt them well.

The forceps should, I think, have been applied earlier in this case, but it is often very difficult to decide when to apply them. I once had a vesico-vaginal fistula occur in one of my own patients and I feel charitably towards other physicians who meet with the accident. In my case, I applied the forceps early, and with immense difficulty delivered a living child, but a few days afterwards there occurred a fistula. It was due to a projecting promontory pressing the head against the symphysis and in this way squeezing the bladder. I felt very much humiliated when I found this fistula. This took place ten years ago, but as I look back I feel perfectly satisfied with what I did. I waited a short time but as the head did not descend, I put on the forceps. When I found an opening had formed, I put in a self-retaining catheter and made one application of nitric acid around the surface and every other day an application of nitrate of silver. The result was that the parts united perfectly.—*Med. Review.*

EMPYEMA COMMUNICATING WITH THE LUNG.

CLINIC BY I. BURNEY YEO, M.D., F.R.C.P., LONDON.

The case to which I wish to call your attention to-day you will do well to study attentively, for it presents an example of one of the greatest triumphs of antiseptic treatment which you can witness.

A——, a ship's captain, forty-one years of age, had been attacked about eight months previously with pneumonia of the left lung, and had never been well since. He had been suffering from cough, emaciation, and severe night sweats, the latter having ceased during the last twelve days. For the past five months he had, at intervals of about ten days, expectorated half a pint or more of fluid at a time, which was said to be muco-purulent. He is thin, and his muscles feel flabby; his countenance has rather a puffy look, and he has a hectic flush. He has some pain on the left side on breathing and a dragging feeling when he lifts his left arm. He cannot lie on the right side. He has a frequent short cough, with greenish muco-purulent expectoration ("slightly fetid"). It was examined microscopically by Dr. Gibbes, but was found free from putrefactive organisms. Pulse 100; respiration 24; tongue clean; appetite fairly good; skin moist. The circumference of both sides of the chest was found equal (18 in. below the nipple, 14½ in. at the base of the xiphoid cartilage). On the left side the inspiratory expansion is greatly diminished. There is dulness on percussion over the whole of the left side of the chest, absolute below the seventh rib upwards. An exception to the general want of resonance is, however, found over an area in front, limited externally by a line drawn from the middle of the clavicle to the fourth rib; here there is hyper-resonance, which seems to cross the sternum and become continuous with the resonance of the right lung; breathing here is loud and somewhat blowing, the vocal fremitus is increased, and there are a few scattered rales heard occasionally. Over the area of absolute dulness there is entire absence of vocal fremitus and of respiratory sounds; above the seventh rib indistinct vocal fremitus can be detected and feeble distant breath sounds. There is no œdema of the chest wall nor any bulging of the chest or of the intercostal spaces, except at one spot in front between the fourth and fifth ribs, where there is a distinctly localised swelling of an area of about two and a half inches by an inch, a little external to the nipple, and projecting about half an inch above the surface; it is tender to the touch, becomes tense on coughing, and an impulse synchronous with the cardiac pulsations is communicated to it. Auscultation over it reveals normal but distant heart sounds and an occasional creak. The heart's impulse is felt (displaced) in the epigastrium and

to the right of the lower half of the sternum; sounds normal. Nothing abnormal to be detected on examination of the right lung. After the examination we concluded that the case was one of purulent effusion in the left pleural cavity, which had effected a communication with the lung, and that periodically, when the tension within the pleural cavity became sufficiently great, a certain quantity of the purulent fluid in the pleura was expelled through the bronchial passages. The swelling in the front of the chest also indicated that the fluid had weakened or perforated a spot between the third and fourth ribs. It would seem as though this fluid, under tension within the pleural cavity, had attempted to discharge itself in two directions, and had found least difficulty on the side of the lung. It is also most likely that adhesions more or less extensive between the surface of the lung and the wall of the chest prevented further compression of the lung, so that the fluid pressure was brought to bear on a portion of comparatively uncompressed lung. It would seem also that the opening into the lung must be a valvular one, opening towards the air passages, and not towards the pleura, for there was no sign whatever of the entrance of air into the pleural cavity. We must also bear in mind that the pressure of the fluid on the surface of the lung would tend to keep the air from escaping from any small opening that had accidentally been made. This was our diagnosis, but resolved to wait until the periodical return of the profuse discharge from the air-passages had again occurred, so that we might observe its amount and character for ourselves. We were the more bound to do this, as the case had come to us with the suggestion that the fluid expectorated might possibly come from a dilated bronchus. We waited fourteen days, during which time our patient presented the symptoms of a mild form of hectic fever, the temperature fluctuating somewhat freely between 99·6° and 103·2°, the pulse ranging between 100 and 120, and the respiration between 24 and 44. On the fourteenth day after his admission he had an attack of profuse expectoration, and in twenty-four hours he brought up twenty ounces of muco-purulent fluid, quite free from fetor and from putrefactive organisms. The dulness and other physical signs remained precisely the same. This discharge was followed by a marked abatement of the fever, the temperature for the next six days scarcely rising above 100°. On the 22nd I introduced the needle of a hypodermic syringe into the pleural cavity, just below the angle of the left scapula, and withdrew twenty minims of perfectly sweet pus, which was examined by Dr. Gibbes, who reported that he found pus and fat cells, a little fibrin, and no septic bacteria. It was now absolutely certain that our diagnosis was correct, and that the contents of the pleural cavity were quite free from any putrefactive change.

We were now in a position to decide what was the best line of treatment to be pursued. It was urgent that something should be done, for the patient was rapidly wasting and being consumed with this hectic fever, and there was also the obvious risk of lardaceous degeneration of organs. It was not a case of aspirating, for in the process of aspiration we ran very considerable risk of sucking air through the lung into the pleural cavity, and so converting a pyothorax into a pneumo-pyothorax. I therefore appealed to Sir Joseph Lister for his counsel and co-operation, which he kindly undertook. The result is one of the most striking triumphs of antiseptic surgery I have ever had the opportunity of seeing. On the 24th the patient was taken into the operating theatre and put under chloroform, and under the spray a crucial incision was made over the seventh left rib in about the mid-axillary line, the periosteum was separated and turned aside with the intercostal vessels, and about two inches of the rib were removed. One of the largest-sized drainage-tubes was then introduced, and sixty ounces of pus were immediately evacuated. No attempt, however, was made to completely evacuate the pleural cavity; on the contrary, the chest was rapidly enveloped in eucalyptus gauze, and the patient removed to bed. The day after the operation the temperature was 98°, and remained at or a little below normal from that time forward. The relief to all the symptoms was complete and immediate. His side felt easier, he slept well, and his cough was less. The urine was dark from carbolic acid. In the evening after the operation the wound was dressed, and, as a considerable quantity of pus had been allowed to remain in the pleural cavity, it discharged freely. The day after the operation air could at times be heard passing in and out of the wound. It was dressed, and the discharge was chiefly serous. On the 26th he had slept well; only coughed once during the night.—28th: Air whistles through drainage-tube on coughing. Cough silent, with very little expectation. In less than six weeks from the date of operation all antiseptic dressings were discontinued, and the opening in the chest was quite closed. He left the hospital, and in every respect perfectly well.

Remarks.—This case is one which has shown in a remarkable manner the advantages of dealing with purulent effusions into the pleural cavity by free incision, under strict antiseptic precautions and free drainage. It shows also that the existence of a communication with the air-passages, such as we had evidence of in this case, presents no bar to rapid recovery after such a procedure, and it also shows that the existence of such an opening does not necessarily lead to decomposition of the purulent contents of the pleural cavity. I have said that in this case the opening was probably valvular towards the lung, and only pushed open when the tension in the pleura reached a certain degree.

But Sir Joseph Lister believes, and has told you, that the presence of the ciliated epithelium along the bronchial passages tends to keep septic particles which may be in the air from reaching the periphery of the lung, and that even though a little air may have escaped into the pleural cavity it would do no harm. Certainly in this case the pus was perfectly sweet and free from organisms, and there was never any auscultatory evidence of air in the pleura. The rapidity and completeness of the recovery in this case were most astonishing to those of us who saw the case, and to the patient himself. He had been laid up for eight months, and when he was admitted into the hospital, and until the date of the operation, he was wasting rapidly from hectic fever; he had lost nearly 5 st. in weight. His temperature fell immediately after the operation, and never rose above normal for the remainder of his stay in hospital. He was able to get up ten days after the operation, and a fortnight after he was walking about the ward to all appearance perfectly well. Within six weeks of the operation he was able to leave the hospital quite recovered and without dressings of any kind.—*Lancet.*

CANCER—FIBROID—PROLAPSED OVARY ANTEFLEXION.

CLINIC BY PROF. T. G. THOMAS.

Our first patient to-day is Mrs. Eliza C—, a native of the United States. She has been married thirty-five years, and I will ask her to tell us in her own words what she is suffering from. She says she has back-ache and the whites; upon questioning her I get the statement that the discharge is water, and to the amount of about a pint and a half in twenty-four hours. These are the only symptoms which she considers important enough to present to us. She has been under the care of several physicians only one of whom has examined her by the vagina. I do not get these points for the purpose of criticising the physicians, but that I may impress upon you the great value of always suggesting a vaginal examination of every patient presenting herself to you with symptoms that lead you to suspect the uterus. Have we anything in the symptoms which this patient presents us tending to criminate the uterus? Doubtless many of you are thinking of the profuse watery discharge and let me earnestly urge you never to prescribe for a woman who speaks of having a watery discharge, until you have examined her, for this is one of the rarest forms of discharges which you will meet with. Bloody or mucous discharges are comparatively common, but when you meet with a vaginal discharge which is profuse and watery, always remember that this is a symptom of malignant disease. I call to mind the case of a lady who was

referred to me by several physicians from a distance, gentlemen whom I know to be intelligent and competent. This lady had been under treatment for a year and a half, but as the only symptom of which she complained was *hyrorrhœa*, none of these gentlemen had made a vaginal examination. Upon examining her I found the cervix entirely gone, and only the fundus and outer wall of the uterus left to shew the results of epithelioma. Now imagine how one of you would feel if you had been treating this lady a year and a half, without having examined her, and then some rival practitioner should be called in and make an examination; but to return to our patient of to-day. When I examined her in the ante-room I found the vagina midway between the cervix uteri and the ostium vagina constricted by a firm, velvety feeling ring of tissue, which is brittle under my finger, easily breaking down. This is malignant tissue and is the cause of the serous discharge by obstructing the blood vessels.

Now we are in the light as far as diagnosis is concerned, but as regard prognosis and treatment we cannot say as much. I have allowed the patient to pass from the room, in order that she may not hear her case discussed. The prognosis in this case is bad. The treatment in her case will be only palliative. The pain in her back will become more severe, and will require opium for its relief. But we cannot cure her; I would not consider an operation advisable. She suspects the nature of her disease, and to reassure her I have told her that she has a disease resembling cancer and called epithelioma.

Our next patient is Mrs. Kate H—, a native of Ireland. She has been married two years, has had two abortions, each at about the third month of utero-gestation. She says she has not been well at all since her last abortion which occurred about seven months ago, has a heavy feeling in the pelvis, soreness extending from the back around and down the thighs, suffers from nausea at times. She suffers menorrhagia and dysmenorrhœa at every menstruation. When I examined her I found the cervix hard and smooth, giving me no evidence of disease, then keeping my fingers against the cervix as I do now against the cervix of the manikin, I placed my other hand over the patient's abdomen in this way, and making pressure downward immediately a flood of light was thrown upon the case, for now I had the uterus between my two hands and was able to make out its position and shape pretty accurately. The uterus is firm and symmetrical, but much larger than the normal non-pregnant uterus. Now what is this condition due to? Is it pregnancy? Judging from the history I did not believe this was the case, for these symptoms have continued constantly since the uterus last evacuated its contents, and there are no other signs of pregnancy. I passed in the uterine sound and found the depth

of the cavity to be about five inches. To be brief I have no doubt but that we have here a case of fibrous tumor of the uterus. Can I be absolutely sure of this? No. When you meet a doctor who professes never to err in diagnosis, you may set him down as either a knave or a fool, for he either deceives himself or tries to deceive you. If you will question any of our best diagnosticians you will hear them say that the best they can do is to constantly try to improve. Now in this case what is your prognosis. This tumor has probably existed since before her marriage. This heavy uterus causes her back-ache by dragging on the uterosacral ligaments and this is a very common cause of back-ache among women, for these ligaments are very sensitive even in health.

This tumor became permanent in her uterus and the uterus refuses to carry a developing fœtus beyond the third month. If this tumor were subserous or interstitial we would not get much hæmorrhage directly from the tumor itself, but we might from the fungoid growths, which the presence of the tumor might excite in the endometrium. If it is an intra-uterine fibroid I would dilate the cervix with sea tangle tents and remove the tumor. I say *sea tangle* tents for I have become disgusted with one tent after another and this seems the least objectionable of any that I have ever used. I prefer the use of several long and slender ones at the same time, introducing them *under* a solution of bichloride of mercury (1-1000) with which the upper part of the vagina is filled, the patient lying in such a position that the os uteri is entirely submerged.

Let me tell you, gentlemen, that when you undertake to dilate the cervix uteri and remove a growth larger than a hen's egg, you are undertaking an operation before which an ordinary ovariectomy sinks into insignificance, for you are working entirely in the dark, may easily perforate the fundus and have no means of knowing whether the growth is all removed or not. Some of you saw me remove an ovarian tumor, yesterday, which weighed forty pounds, but I consider that a more trivial operation than removing an intra-uterine tumor the size of my fist. Don't forget that I am not giving you a didactic lecture upon fibroid tumors of the uterus, but a clinical lecture upon the case now before us. To-morrow some of you will see me remove both ovaries from a woman for the cure of a fibroid tumor and so is that, but they are as entirely different as possible. I frequently see statements attributed to me which I have been spending years in trying to controvert, so if any of you are taking notes for publication let me see your notes before you have them printed, for often the changing of a punctuation or a letter may alter the whole meaning of a sentence. As an illustration allow me to relate a little incident occurring in the practice of my friend Dr. B., who was summoned to attend a young lady student at a boarding school in this city.

Being requested to inform her father by telegraph of her condition he wrote the following message: "Your daughter is all right, she has had a chill," but the operator converted the "l" into a "d" which message brought the irate father to the city on the next train. By just as simple an error, a lecturer is sometimes unintentionally misquoted.

Our next patient, gentlemen, is Mrs. Dora L—, a native of the United States. She has been married for two years, and has had one child, which was born nine months ago. She nurses it, but has been sick for the past six months; she says she has back-ache and constant "bearing down," which she defines as "feeling as though her insides needed pushing up." She has pain in the left side and occasional attacks of giddiness. She has menstruated once since her baby was born. Upon examining her, I find lying down behind the uterus in Douglas's *cul de sac*, the cause of the trouble, an egg-like tumor, about the size of this one which I attach to the mannikin; this is freely movable, and I can easily practice ballottement upon it as I would upon a three months's fetus. When I grasp it the patient is restless and says that is where her trouble lies. This, then, is a prolapsed ovary, probably the left, and I believe it to be in a cystic degeneration. What is the treatment for a cystic ovary? Operative or palliative according to the case. A few years ago I introduced an operation for the removal of the ovary through a vaginal incision, but I have abandoned the operation now in favor of the abdominal incision. You may think the other would be the simpler operation, but it has not been followed by as good results, either at my hands, or those of others. However, I would not advise an operation in this case, but would employ cannabis indica internally, and locally the action of the galvanic current passed through the ovary. I will try and get this woman into my service at the Woman's Hospital, and see you again in one month, to report her condition.

Our next patient is Miss Addie W—, æt 36 a native of the United States, says she has been sick seven years, but upon questioning her, I elicit the statement that she has always suffered at her monthly periods, with the exception of the first two or three menstruations, which began when she was fourteen years of age. The pain begins several days before the flow of blood appears, and continues throughout her menstruation, fading gradually so that she is free from pain only a short time before her next attack begins; she never passes any clots. You read so much in the medical journals about dysmenorrhœa, that you are liable to be greatly confused concerning it, but please remember that it is only a symptom and when you have found and removed the cause the dysmenorrhœa will disappear. Before I examined this patient, I said to myself that I should find a small uterus sharply ante-flexed, and I so found it. How was I able to

judge of this case. Well, because I have seen so many cases exactly like it; the endometrium is as sensitive as a carious tooth. The first thing this patient asks is, can you cure me? I answer her that, without an operation, I cannot cure her, and that with one, I may. I will try to get her into the Woman's Hospital, and will have her come again to this clinic. The operation would consist in straightening the uterus, and then with a narrow bistoury introduced beyond the constriction, I would make four incisions, each about an eighth of an inch in depth, one in front, one in the back, and one on each side, then I would introduce into the cavity a glass stem solid, with a round upper end, curved as a normal uterine canal, and short enough so that it should not press against the fundus. The lower end of the stem is a knob and rests in a cup pessary. This apparatus should be worn for about six months, it does not interfere with menstruation, and causes little irritation. If it is removed at the end of this time the uterus will often retain its proper place, but sometimes there is a tendency for it to resume its old position after two or three years; in these cases we may do the operation over again for if done with antiseptic precautions, it is far from a serious operation, and three or even two years' immunity from pain is worth the trouble.—*Detroit Lancet*.

RECENT METHODS OF TREATING COLD ABSCESSSES.

Professor Billroth, of Vienna, writing on the above subject (*Medical Press and Circular*, January 16, 1884); says:—When we turn our thoughts to a cold abscess we must first of all place before ourselves the questions, Why is not the contained fluid absorbed? and why are we compelled either to await its opening or open it ourselves?

Exudations that arise in the course of acute inflammations, or transitory disturbances of circulation, are indeed usually absorbed; if the general condition of the body is in other ways normal, the absorption of the fluid is the ordinary process. If you have a clear conception of the arrangement of the lymphatic vascular system you will comprehend this, for the lymphatic vascular system sucks up all these exudation products like a sponge, and carries them all back into the blood channels. Under what conditions, then, does this resorption fail to take place? (1.) You may say first that absence of open lymph vessels is a very important cause, and that is just the case with the capsule that in the course of time forms around these abscesses. The walls of the veins can, it is true, take up some of the fluid, but it is the open lymph vessels that are most concerned in such absorption. But even when such open lymph courses are present, that may become closed under certain circumstances,

as by an exudation that becomes clotted, in which fibrine forms quickly, and in which the clotting may be continued into the lymph vessels, or into the interstitial structural interspaces. This is the case to a great extent in croupous and diphtheritic exudations. (2.) The resorption is dependent on the degree of concentration of the fluid. If the fluid is to be resorbed, its concentration must be less than that of the blood. That is not the case in cold abscesses. Moreover the various regions of the body show great differences in their power of resorption; the pelvis is the most favorable for resorption; the most unfavorable is the pleural cavity. How can we overcome these difficulties therapeutically? (1.) The first method would be the removal of the fluid; but experience teaches that the fluid may be removed for the moment, but that the exudative property of the structure does not cease; on the contrary, the cavity refills with uncommon rapidity with pus, this refilling being principally caused by the fact that by the removal of the fluid the vessels in the abscess walls are subjected to a greatly reduced pressure. (2.) Is it possible by certain irritating agents to excite a greater vascularity in the walls of the abscess? With this object in view tincture of iodine has been injected, for the purpose of exciting an inflammation, whereby an exudation is certainly set up, but which, in consequence of the higher vascularity thus induced, is readily absorbed, with the result that the cavity shrinks up. (3.) This method was succeeded by the opening of the abscess under strict antiseptic precautions. Not only is the pus evacuated, but the abscess cavity is carefully scraped with the sharp spoon, after which an antiseptic dressing is applied. In this way the walls of the abscess, which consist of a mass of soft granulations, are removed as far as the healthy tissues, whereby, by means of a light compress, healing by first intention has been achieved. Indeed by this method good results have been obtained in many cases, but it is one that requires to be carried out with great accuracy. Since the introduction of iodoform we have strewn the scraped-out cavity together with the exception of the openings left for drainage. By means of iodoform, sepsis is to a great extent avoided, and under certain circumstances granulations may spring up under which healing rapidly takes place. (4.) Quite recently we have attempted another method, namely, puncture of the abscess, and subsequent injection of an emulsion of iodoform consisting of ten parts of iodoform to 100 parts of glycerine. The emulsion must be well shaken up before using, and then, according to the size of the abscess, twenty to thirty grammes are to be injected. In most of the cases in which this method has been attempted the course has been free from reaction, only moderate swelling has taken place, and but little pain has

been present. This, however, would only indicate that the treatment has done no harm; it is also desirable that it should bring about the shrinking of the abscess, and that the fluid remaining in the cavity should be absorbed. As a matter of fact, the results in some cases were exceedingly favorable, but further experience is necessary to show whether the iodoform emulsion is still to be continued. Generally speaking, I should advise you, unless there should be some reason for it, not to open the cold abscess, but to allow it to open spontaneously, especially if you cannot watch over your patients closely. You can then calculate with certainty that the pus will escape without fever and without further reaction, whilst at the same time the entrance of air is completely avoided. In such cases the mechanical relations are extremely favorable, even wonderfully so, without our being able to give an explanation of them, for it happens, for example, that an abscess bursts into the bladder or rectum, and in such cases I have never seen urine or intestinal gases enter the abscess cavity. Under strict antiseptic precautions, and under your constant supervision, you may open the abscess, especially if you suspect with some certainty that you can easily reach the bone from which the abscess springs, or if it causes by its great expansion compression of the neighboring structures, and in consequence of this gives rise to various difficulties.

EXTRACTUM PANCREATIS IN TYPHOID FEVER.

In the *American Practitioner*, for January 1884, Dr. Frank C. Wilson, Professor of Physiology in the Hospital College of Medicine, Louisville, Ky., gives his experience of the use of the above remedy:

In typhoid fever, more than in any other disease, do the indications point clearly and emphatically to the most careful dietetic management of the case, from the beginning to the end of it. The debilitating effect of the continued fever, protracted through a period of four or six weeks and sometimes even longer, must be combated in every possible way, and yet without adding to the danger of loading the intestines with undigested food, of itself a source of evil and discomfort. Only that which is absorbed and assimilated, is of real service to the system. In the enfeebled condition of the digestive organs very little of the food taken into the stomach can or will be digested, but passes down through the intestinal tract in a constantly fermenting state, thus adding to the discomfort by the increasing flatus, and over the inflamed and ulcerated Peyer's patches, producing possibly hemorrhage, or even death, by perforation. The great danger from this source has led some eminent physicians to advocate even total abstinence from

food, confining the patient strictly to water, even for three or four weeks. If, however, food can be so thoroughly digested, before being taken into the stomach, that all will be readily absorbed and assimilated, leaving no residue, the indications will be fulfilled. Milk is the article of diet usually relied upon for feeding typhoid fever patients, but even when the digestive organs are in a healthy condition it coagulates into a mass of curd as soon as it reaches the stomach. This hard mass has then to be digested and disintegrated before being absorbed. If this fails to be accomplished by reason of the small quantity or poor quality of the digestive fluids, the irritating mass passes down through the intestines, a constant source of annoyance and danger. This may all be obviated by digesting the milk with the pancreatic extract, as prepared by Fairchild Bros. & Foster, of New York. Milk so treated cannot be coagulated by even the strongest acids, its casein being transformed into peptone and in condition to be at once absorbed and assimilated. There is noticeable a slight bitterness, to which the patient soon becomes accustomed, so that it is taken readily and produces no discomfort. Even this bitter taste may be avoided by stopping the process of digestion before it is entirely completed. It has been found by experiment that the objectionable taste is only developed when the casein is entirely peptonized. It is scarcely ever necessary to carry the artificial digestion quite so far, and when stopped at any point before completion the taste is perfectly natural. If immediately placed on ice, it can be kept as long as undigested milk. The ferment of the pancreatic extract is held in a latent condition, and when taken into the intestinal canal may still further aid in the completion of the digestive process.

To avoid the possibility of the patient becoming tired of the same article of diet, day after day, its form of administration may be varied in a number of ways. As the casein is peptonized, and cannot be coagulated by even the stronger acids, the milk so prepared can be utilized in making milk punch. This can be flavored with lemon juice or any other acid desired. Thickened with gelatin, sweetened and flavored, it forms a delicious milk jelly suitable for convalescent patients and grateful to the taste.

During the past two years I have met with many instances in which the use of the pancreatic extract has yielded the most gratifying results. Not alone in typhoid fever is it useful, but in all instances where the digestion is enfeebled, or where it is interfered with by the presence of ulcerated or inflamed surfaces, the process of peptonizing the food will be found of service. In rectal alimentation its importance is manifest, the food so prepared being readily absorbed and appropriated without inconvenience or irritation. I have sustained patients with gastric ulcer entirely by nutritive enemata twelve or fourteen days. In this time the ulcer

will be entirely healed, so as to allow the cautious administration of peptonized milk in gradually increasing quantity, until a full meal can be taken.

To Dr. Roberts, who first suggested the importance of peptonizing the food, and to the Fairchild Brothers, whose pancreatic extract enables us to do so readily and thoroughly accomplish it, the profession owes an everlasting debt of gratitude, echoed by many patients whose lives have been saved by its use.

THE THERAPEUTIC USE OF HOT WATER TAKEN INTERNALLY.

This is the subject of a very interesting article by Dr. Ephraim Cutter in *Gaillard's Medical Journal*. The article starts out with a *resumé* of the history of this therapeutic measure. It originated in 1858 with Dr. James N. Salisbury, who undertook a series of extended experiments with a view to demonstrating the correctness of the theory on the strength of which the practice is based. Its object is to remove from the stomach the results of processes complicating digestion, but necessarily a part of it, the principal of these processes being fermentation. The results of fermentation in the stomach are acetic, butyric, hydrosulphuric, lactic and saccharic acids, and sulphide of ammonium, vegetations and yeasts. The absorption of these gives rise to a variety of constitutional disturbances, which may even result in organic trouble, the seat of this organic trouble being the lungs, the liver and the kidneys, or other organs. It is probably generally well known, that Dr. Salisbury associates the absorption of these products of fermentation very directly with the causation of phthisis pulmonalis, and it is upon the assumption of this connection of cause and effect that he bases his well-known treatment of this disease by raw meat diet and copious washings of the stomach with hot water. Dr. Cutter is an enthusiastic disciple of Dr. Salisbury, and has done probably more than Dr. Salisbury to familiarize the profession with the latter's peculiar views and practices. The article gives explicit directions for the carrying out of this hot water treatment.

1. The water must be hot—not cold or lukewarm. The reasons for this are principally that cold water depresses, and that lukewarm water excites vomiting. By hot water is meant a temperature of 110° to 150° Fahrenheit, such as is commonly liked in the use of tea and coffee.

2. As to the quantity of water: The commencing amount should not be less than half a pint, which amount must be gradually increased with the capacity of the patient, until the specific gravity of the urine stands at 1015 to 1020, the best standard of health. If on examination of the urine the specific gravity stands at 1030 more hot water

should be drunk. On the other hand, should it fall to 1010, the amount should be decreased.

3. The time for taking hot water is an hour or two before each meal and half an hour before retiring.

4. The water should not be drunk too fast. It should rather be sipped, so that the stomach may not be so rapidly distended as to make it feel uncomfortable.

5. The length of time during which this hot water treatment should be continued is six months, this time being usually required to thoroughly wash out the liver and the intestines.

6. Should it be desired to add to the palatability of the hot water it may be medicated with clover blossoms, tea, ginger, lemon juice, sage, salt, and even occasionally sulphate of magnesia. When the thirst is intense a pinch of chloride of calcium or nitrate of potash may be added.

7. The amount of liquid to be drunk at a meal should not exceed eight ounces. This amount should not be exceeded, in order that the gastric juice may not be unduly diluted, or that the contents of the stomach may not be prematurely washed out.

It is claimed that under this treatment the fæces become black, the discoloration being due to the washing of the bile down its normal channel. While this blackness may last for more than six months the foetid odor of ordinary fæces is abated and the smell approximates that of the fæces of healthy sucking infants. The urine becomes as clear as champagne, free from deposit on cooling and free from odor. The various secreting organs are said to improve as to their functions and a general feeling of well-being takes possession of the hitherto overlaid and consequently inactive body.

The following is a summary of the general conclusions on the therapeutical drinking of hot water as given by Dr. Cutter. He claims it to be the foundation for all treatment of chronic diseases. It excites downward peristalsis. It relieves spasm or colic of the bowels by applying the relaxing influence of heat inside the alimentary canal, just as heat applied outside the abdomen relieves. It dilutes the ropy secretions of the whole body and renders them less adhesive, sticky and tenacious. It is an inside bath. It dissolves the abnormal crystallized substances that may be in the blood and urine. It washes down the bile, mucus, yeast and waste, and thus leaves the stomach fresh and clean for the function of digestion. It promotes elimination everywhere.

It is necessary in conducting this treatment that the stomach should be rid of the hot water before meals, and this for reasons which are too obvious to require mention.

While we think it possible that Dr. Cutter has attached undue value to this means of cure, we cannot dispute the fact that the number of cases

to which it is applicable is great. We should think it peculiarly applicable in the case of those who habitually gorge themselves, and whose systems are always overloaded with matter which the emunctory organs, constantly overtaxed, are unable to eliminate from the system. The thorough washing out which copious draughts of hot water would favor must be very beneficial in cases of this kind. *Therapeutic Gazette.*

MEDICAL EDUCATION IN CANADA.

The *N. Y. Med. Record* March 8, 1884, has the following in regard to Medical Education in Canada :

The medical schools in the Dominion of Canada compare favorably with those in other countries. The cities are smaller, and in this respect may not afford as good a field for practical teaching as is to be found in the larger centres ; yet their material, as far as it goes, is very thoroughly used. It does not follow that because a city is large the advantages in practical work must be greater than in a smaller one.

There is now, and for some time past, a distinct tendency toward the practical in medical teaching. While didactic lectures are still given, and perhaps with greater care and zeal than ever, there is added that other great factor in medical education—observation. The various schools vie with each other in the efficiency of the practical department of the work. Anatomy is being taught very much by constant demonstrations, the microscope is placed in the hands of every student, and the test-tube is as familiar as the scalpel. This change has been brought about mainly by the changes in the course of study and the mode of examinations. The qualifying bodies now require that a fair percentage of the lectures must be practical. Whenever the dissected subject was used to examine candidates upon in the various years, students found it to their best interest to spend much of their time in the dissecting-room ; and, instead of avoiding this part of the work, there was a run for material and practical teaching.

When the bedside test of the student was inserted as part of the examination, clinics became a great necessity ; and more of the school men began giving this department a larger share of their time and attention. No matter how anxious the teachers may be to impart instruction, or students to acquire it, the plan of Canadian hospitals can hardly be regarded as ideal in this respect. The advances which have been made in medical education necessitate better and more efficiently equipped schools ; but there is not so much hope for larger and better arranged hospitals. These latter are intended for the sick, and so long as they meet public wants in this respect, no great change

need be looked for. The material at the command of nearly all the medical schools is quite up to their requirements, and is very thoroughly used, notwithstanding many obstacles.

The entrance examination, fixed by the different licensing, or degree-granting bodies, is fairly high. It compares well with that found in Great Britain. This part of the course is very compulsory; for none can enter upon their studies and obtain a qualification in medicine without it. This preliminary examination being over, the course consists in four winter sessions. The examinations differ in different universities and licensing bodies. In some the work is divided into a primary and final group of studies, while in others there is an annual examination at the close of each session.

From a somewhat extended acquaintanceship with the state of medical education in the United States and in Great Britain, we cannot but think that Canada compares very favorably with both. It must be admitted that such old and large centres as Edinburgh, London, New York and Philadelphia would have advantages peculiarly their own. Yet when we look at the advantages and disadvantages to medical education in Canada, at the careful manner in which both theoretical and practical teaching is given, at the high standard fixed by the different curricula, it must be admitted that these schools are turning out a very efficient class of practitioners.

If there be any serious error in the Canadian system of medical education, it is rather one of excess than one of defect. Several of the branches of study might, perhaps, be dropped out of the course altogether; or at least less attention paid to them. Such subjects as botany, zoology, and chemistry cannot be regarded of such prime importance as physiology and anatomy, and yet at present they receive a very great deal of attention. Pathology lately has been assuming its true position by receiving something like the attention it deserves.

MODERN ABUSES IN MEDICINE.

The following extracts are given from the address of Dr. Alexander Hutchins, President of the Medical Society, State of New York (*New York Med. Journal*):

A good physician is not necessarily a learned man. Experience, sagacious observation, strong intuitive perceptions, with the minimum facility in advanced appliances, have made, and will continue to make, successful practitioners of medicine. But these are not the teachings of text-books, and are not the themes of the medical lecturer. However, it will hardly be questioned that skill in differential diagnosis is the safe basis of treatment, and varied resources in medical art leads most rapidly to the best results; and the faithful student in the pro-

fession is the one most keenly alive to the importance of both. When the pre-eminent importance of accurate diagnosis is considered, when the difficulties that environ its acquisition are appreciated, when it is understood how patient and enduring are the observations that lead up to the mastery of the nomenclature of medicine and the comprehension of the varied conditions it represents, it is humiliating to hear the most profound disorders that afflict mankind bandied about in common speech as the veriest playthings of the hour. The diphtherias that come into homes as plentifully as summer showers over the landscape and pass away as soon; the peritonitis that disturbs the quiet of the night and is dissipated with the morning dew; the pneumonia and spinal meningitis, that early recognition and prompt specifics lead in a few days to vigorous health, are all recounted with flippancy unconcern, in drawing-room and social circle, on the highway, in the mart. These are not the manufacture of the people, for the terms are foreign to domestic culture. It were refined cruelty to charge upon the doctor such consummate ignorance; better far to credit him with the knavery that can command untruth to advance his interests or fortune.

On the other hand, it is asking too much of credulity to believe that the attitude of the profession is friendly to the community when the lavish gift of the doctorate puts into so many undisciplined hands the medical arts which are as potent for evil as for good. It is too much to assert that uncertainty of diagnosis runs parallel with the free use of drugs, and that confidence in specific therapeutics decreases with experience at the bedside? What inferences are deducible in this direction from the multiplying drug-stores and the rapidly enlarging business enterprise of the great manufacturing chemists? Is it supposable that the ingenious activity of pharmaceutical industry, in devising the protean forms and potencies of foods and medicine, is all on the side of the public interest? Does it appeal to the public direct, or is it profitable through the medium of the profession, who acts as agents to benefit the manufacturer at the expense of the people—the only commission being the desertion of the tried for floundering experiment with the novel? Does the percentage from the truss-man and the druggist mean anything more than the struggle of incompetency to eke out a livelihood at increased cost to the people? Is the community safer with broadcast hypodermic morphia, aconitia, and strychnia (vegetable medicines, forsooth) than with a blind surgeon exsecting a tumor from the axilla? Whence comes this malaria, that has jaundiced the speech of men, but from the track of the scapegoat making for the wilderness, burdened with the easy diagnosis of lazy incompetence? Has the clinical thermometer proved an unmixed good, when every pyrexia

is the impetus to indiscriminate quinine? and who is responsible for the "one cent a grain in pill or powder" that blazon in the sunlight through colored globes in shop-windows along every thoroughfare? Has the speculum contributed to the moral sense of the community, while prurient or needless interference with most cruel vandalism is invading the sanctity of the home and making the daughters of the land wise before the time?

Humiliating and unsavory though it be, the regnant fact holds true that—coupled with that large body of men who acknowledge an ancestry of scholars and faithful students of nature, who base their art on principles which have survived criticism, who practice their art in the interest of the physical and spiritual well-being of their fellow-men, whose livelihood is a legitimate product of their worthy and acceptable service—there is another and large class, known not only to the census enumerator but to the community by the same name, with equal protection under the law, who, with insufficient culture and consciences dulled through habitual and ignorant tampering with grave responsibilities (described lately by an influential medical journal, as "hangers-on of whom any party would be ashamed"), are a standing menace to the community, which, accepting all as competitors in the race, gives to all alike its patronage and its support.

THE TREATMENT OF RHEUMATISM— TYSON.

I shall devote the few remaining minutes of the hour to the consideration of a case of rheumatism. He gives the following history. He is 37 years of age. Seven years ago he had typhoid fever, and five years ago he had rheumatism in the left shoulder, hand, and foot. The present sickness began in December, 1882. While cutting ice he became wet, and remained in his wet clothing for half an hour. The next day he was taken sick with fever. The right wrist soon became swollen. The swelling next affected the right ankle, and then the left ankle. Looking at his wrists you observe a peculiar deformity, which is due to accumulation of fluid. In other words, these joints are the seat of rheumatic synovitis. The joints of the feet are also affected. The early history of this case is typical of acute articular rheumatism. The form of exposure which preceded the development of acute symptoms is that which is peculiarly prone to develop acute articular rheumatism. I refer to exposure to cold and wet combined. The swelling and pain left one joint to appear in another. This is characteristic of rheumatism. He has never been well since this attack developed, and there is now a condition of subacute rheumatism.

When taken sick he sought no advice but that which he could gain at a drug store. He was

given something to take internally, and a liniment to rub the affected joints. This is just the sort of treatment we should expect to be followed by the chronic form. It used to be said that the best cure for rheumatism was "six weeks," by which was meant that there was no remedy which was of especial service in this affection, and that under ordinary circumstances it would get well of itself in six weeks. Although this may have been true then, it is not true at the present time. There is no doubt that we have in salicylic acid and the salicylate of sodium remedies which greatly increase our power over rheumatism. We now take hold of a case of acute rheumatism with the greatest confidence. In my own experience I do not recall a single case of acute articular rheumatism coming under observation at an early period in which salicylate of sodium failed to bring about a cure. If this man had been properly treated, he probably would not have been here to-day.

My method of giving salicylate of sodium is to administer ten grains every two hours, and continue until the pain has disappeared and the swelling diminished. After the disease has yielded, it does not do to stop the treatment, but the remedy must be continued for ten days or more, ten grains being given every four hours.

Salicylate of sodium is not the only remedy of use in acute rheumatism, and there are certain conditions which call for a modification of the treatment. When the patient has not been in a condition of previous good health, but has been depressed by unfavorable hygienic surroundings, it is often necessary to combine iron with the salicylic acid. At times iron alone is sufficient.

After a case has passed into the subacute form, as in the present instance, how is it to be treated? Is salicylic acid of any service in this condition? It may be, although less certainly than in acute rheumatism. At the same time, I am apt to begin the treatment with salicylic acid; but the method in which I have most confidence is that by counter-irritation with fly-blisters. A blister one or two inches square should be applied over the various joints in succession, and the counter-irritation kept up for weeks. In a case like this it is not always necessary to resort to so formidable a remedy as blisters. Painting the parts with iodine will sometimes cause absorption of the fluid and the disappearance of the symptoms. The internal use of iodine and iodide of potassium is also resorted to in these cases. Iodide of potassium may be given in doses of ten grains three times a day, or Lugol's solution may be substituted and continued for a considerable length of time.

The question has probably arisen in your minds, is salicylate of sodium of service in what is called muscular rheumatism? It is not nearly so useful in this affection as in acute articular rheumatism. Although I have known it to be occasionally of

service in such cases, the best treatment in my experience for muscular rheumatism is dry and moist heat, and moist heat in the majority of cases. This form of heat is obtained by the use of hot baths. I have recently used, with much satisfaction hot soda-baths, in which from half a pound to a pound of washing soda is added to an ordinary bath of hot water. This should be taken on going to bed. The use of dry heat is also of service. One of the most annoying forms of muscular rheumatism is the ordinary stiff neck. The best remedy for this condition is a gum bag filled with hot water, on which the neck should be laid on going to bed. In the majority of cases the pain will have disappeared before morning.—*Medical Times*.

A SIMPLE FORM OF NASAL DOUCHE.

Dr. Frank Woodbury describes the following simple form of nasal douche in the *Med. Times*, Philadelphia, for July 14, 1883:—The douche consists of an \cap -shaped elbow of glass tube, to which is attached a short (about three inches) piece of ordinary rubber tubing on one arm, and a long (twenty inches) piece from the other, the latter having a hollow, somewhat conical, glass nozzle, so as to occlude the nostril when pressed into it, and keep in the fluid delivered through a central opening. The short end is also tipped with a glass tube so as to hold it open and pre-



vent collapsing. When not in use the entire apparatus is contained in a small paper box ($2\frac{1}{4} \times 1\frac{1}{4} \times 1$ inch), which may be conveniently carried in the pocket, or may be carried in a valise without breaking. In order to use the douche, a glass tumbler, or any similar receptacle, should have placed in it the required amount of warm water (100° F.), medicated as desired; the douche should be immersed in the fluid, and the long tube (tightly pinched between the fingers so as to retain its contents) is drawn out of the reservoir until the glass elbow hooks over the edge of the cup, where it is self-retaining; the fluid will flow from the nozzle as long as it is depressed below the level of the receiver. The flow can be interrupted by simply dropping the nozzle back into the tumbler. It fulfils perfectly the purposes of a nasal douche,

where such an instrument is desired. The douche may also be used for acute affections of the ear after scarlet fever, etc.), for the eye, and generally for such purposes as an instrument of this size is adapted; among these may be mentioned the administration of milk, broth, etc., to patients unable to sit up, and too weak to drink in the ordinary way.

The advantages of this form of nasal douche are (1) its simplicity, there being no parts that can rust or get out of order; if any portion is broken it can be replaced at a trifling cost; (2) its convenience, being compact in form, occupying little space, taking but a moment to put in operation; (3) its safety, the stream being delivered without force, simply by gravity; it is almost impossible that the fluid should be forced into the middle ear; and (4) its efficacy being granted, its chief advantage is that it is the most economical douche that is in the market, its cost being insignificant. In common with every one engaged in general practice, I have found patients for whom a nasal douche might be useful for a short time, but the comparative expensiveness of the Thudichum's douche, and its danger of breakage, have often made me hesitate before ordering it. On this account I devised the simple form which I have presented to-night. Any one can make one for himself in a few minutes at a cost of about twenty-five cents. The rubber tubing costs ten cents per foot, and the glass a trifle only.

ECZEMA MARGINATUM AND RINGWORM IN GENERAL.—Dr. R. W. Taylor (*Four. Cutaneous and Venereal Diseases*, Feb. 1884) says: I have always placed much confidence in the parasiticide virtues of bichloride of mercury in the treatment of the various forms of ringworm, and have generally used it in the alcoholic solution, being in accord with Cavafy in the opinion that, thus used, its efficacy is much enhanced. Even thus combined, its action is not always certain, particularly in cases of eczema marginatum. This fact was very forcibly brought to my mind in the treatment of the case of a young lady during the past summer. She had this affection, severely involving the integument of the hypogastric, pubic, crural, and gluteal regions. The diagnosis was confirmed by the discovery of the parasite in the scales, but the appearances of the eruption were thoroughly typical. I ordered a two-grain solution of the bichloride of mercury in one ounce of alcohol, which was used for about a week, when I increased the strength to four grains, as the progress was not satisfactory. Though the parts were carefully sopped with this solution three or four times a day, and care was taken that the under-clothes would be frequently changed, the rings of eruption advanced, in many parts being preceded by outlying papules. The pruritus was

only relieved for a limited period after each application. In this state of affairs, it occurred to me that, if I could find some vehicle by which the parasiticide could be kept continually over the morbid surfaces, and not be rubbed off, I could soon effect a cure. It happened one day, when the progress of the case was thus at a stand-still, that I had on my office table a bottle of tincture of myrrh. The thought occurred to me that, if the liquid was painted over the surface, a very flexible layer of gum resin would be left which would retain the bichloride of mercury in contact with the skin; I, therefore, first thoroughly bathed the parts with a four-grain-to-the-ounce alcoholic solution of the bichloride, and, when dry, painted the whole surface with the tincture of myrrh. The lady reported, the next day, that she was much better and had not scratched very much since the application. I then gave her a prescription containing four grains of the bichloride to the ounce of tincture of myrrh, with directions to thoroughly paint the parts twice daily. The effect was simply wonderful. In a few days the patches and rings became less red, the papules less salient, the pruritus was relieved, and, within a fortnight, the disease was wholly cured. I have since used the simple and compound tinctures of benzoin in the same way, and find they are equally as valuable in affording a vehicle for the parasiticide and a protective film to the integument. The discomfort of the application is an inconvenience which is more than counterbalanced by the relief of the pruritus. I have thus far used this method in three cases of eczema marginatum and two of tinea tonsurans capitis; in all with most excellent results, namely, a prompt and perfect cure. Whether the gum resins have any therapeutic effect I am unable to say. I think that these tinctures can be still further used with benefit as a vehicle for other agents in the treatment of skin affections.

LISTERISM SIMPLIFIED.—Sir Joseph Lister in a discussion before the Woolwich Military Medical Society said:—He had long held that of all the parts the spray was the least important. It would not break his heart if he were told that he was never to use the spray again. But that fact was not an argument against the use of antiseptic surgery by military surgeons. If the wound be washed after the operation with antiseptic solution, splendid results could be obtained without the spray. One point of simplification would be the employment of a lotion of corrosive sublimate, which had wonderful antiseptic properties, was exceedingly cheap (2s. per pound), and a small quantity was sufficient as an antiseptic (1 to 1000). The material called "wood-wool" was a soft and elastic material, made by tearing up pine wood, which was exceedingly cheap but very bulky, though when impregnated with corrosive sublimate it made a very efficient

antiseptic dressing. He went on to say that he had lately been engaged in some experiments, and had lighted on what he believed was a new fact in chemistry—viz., that corrosive sublimate was wonderfully soluble in glycerine. It was soluble in one and a half times its weight of glycerine in the cold. This circumstance was, he believed, the key to the application of corrosive sublimate in a more compact form. Besides "wood-wool" we had rags which would be highly absorbent. If we dissolved corrosive sublimate in an equal part of glycerine in 200 parts of water, we should have a solution of the required strength. This solution could be used in place of carbolic acid where it was necessary to interfere with the wound in the first line of aid. The materials for its manufacture were extremely portable. The solution would render a sponge aseptic better than carbolic acid, for corrosive sublimate was not volatile. Catgut ligature need not be kept in carbolic oil. For the first dressing Sir Joseph thought iodoform, though by no means the most powerful antiseptic, would be the best. Iodoform did not seem to protect against erysipelas, like carbolic; it was but little soluble in water or the discharges from the wound, and had no irritating properties. Recently, Lesser of Leipzig, in the *Centralblatt für Chirurgie*, had recommended an antiseptic powder carried by the soldier in an empty cartridge; this was composed of two parts of boracic acid and one of iodoform, but Sir Joseph thought pure iodoform would be more effective. Four yards of bandage of open cotton texture impregnated with spermaceti and a layer of absorbent cotton-wool with a three-cornered handkerchief might be carried by the soldier. A small dredging box might be used instead of the cartridge box for carrying the antiseptic powder. A dressing made of these materials might be left on twenty-four or forty-eight hours, or even until healing was complete.—*Lancet*.

THE USE OF HYDROBROMIC ACID.—Dr. Joseph Parish, of Burlington, N. J., writes, referring to an article by Dr. C. L. Dana, (*Journal of Nervous and Mental Diseases*), on hydrobromic acid, that he has recently used it in two cases: "In one, it relieves the insomnia in fl. 3 j doses, taken p.m., say three doses a few hours before retiring. The other is a neurasthenic case, in which there is enlargement and hardening of the sciatic nerve and general neuralgia. In this case I have given the bromides in several forms with but little impression, except bromism. Hoping to avoid the bromism, I resorted to ten per cent. acid, with the effect of bringing out the bromism as distinctly as when she took either of the salts. In direct opposition to this case, I have a lady of forty, an epileptic, who has taken bromide of potassium, in doses of from half a drachm to a drachm and a half, three times daily, for the last fourteen years, without the slightest sign of bromism."

Dr. Squibb writes of hydrobromic acid in *Ephemeris*: "Its most common, and probably most effective use, is as an addition, either constantly or intermittently, to solutions of the bromides when these have to be taken for a long time and in full doses. In this way full bromide doses may be easily maintained, while the effect of the bases is diminished. Full doses of the acid are difficult to administer on account of its intense acidity. It is best given with sugar, or with syrup, or with the syrup of acacia, and with lemon syrup it is somewhat like lemonade. Large dilution is always advisable. The dose of the officinal acid is 2 to 4 fluidrachms, which is equal in bromine to 17 or 34 grains of the potassium salt. An equivalent dose of the 34 per cent. acid is about 27 to 54 minims. This acid is very useful in making extemporaneous solutions of many bromides. For example, the very effective bromide of lithium may be very easily made extemporaneously by prescription, by simply saturating, or nearly saturating, the acid with lithium carbonate."—*Medical Summary, December, 1883.*

PHYSICIANS' FEES.—Quite a discussion is now in progress in London over the question of fees. It appears that even in London the medical gentlemen of long practice and established reputation do not always charge a fee in proportion to the dignity of their position. The consequence is that the junior members of the profession claim that they must either make their charges ridiculously small or do no business as the public would prefer to employ the physician of large reputation at the same price. The fault seems to lie very much there as here. Our profession does not place a sufficiently high estimate on its services. Too many reputable physicians charge ridiculously low fees. With such low fees an enormous amount of work must be done to realise a living income. With us, if a physician charge a good round fee it is difficult for him to get the support of his professional brethren in collecting it. Our profession might very well learn a lesson from our legal brethren. Compare, for example, the fees granted the physicians in President Garfield's case, and lawyers fees in the Star Route case. In each example the case was lost. In each high medical and legal talent was employed. The physicians' bills were cut down to a modicum of the fee demanded. The lawyers' bills more than double what the physicians demanded, were paid in full. The physicians all over the country united in crying out against the exorbitant medical charges. The lawyers all thought the fees demanded by their colleagues were no more than just.

If we desire to maintain the dignity of our profession we must place a fair estimate upon our professional services, and we must stop denouncing as exorbitant the fees which are charged by any other reputable practitioner.—*Cin. Lancet and Clinic.*

MANAGEMENT OF NEW-BORN INFANTS.—The *Med. World* says: In the management of the new-born infant we are gradually approaching nature's methods. In the maternity department of the Woman's Hospital in Philadelphia the management of new-born babes has been as follows: As soon as the head is born the eyes are washed with an antiseptic solution. When the body is born the child is left in the bed to await the expulsion of the placenta. No effort is made to remove the placenta under half or three-quarters of an hour; before this time it is generally expelled by nature. When the placenta is expelled it is placed in a pan, and the child is wrapped up and laid away *with the placenta still attached*. The child is now left and the attention is given to the mother. After the mother is properly cared for, the child receives attention. By this time the pulsations in the cord have long since ceased. The cord is now cut and the blood is "stripped" out of the stump but neither end is ligated. The stump is not dressed, nor is any band put around the child's body. The child is neither washed nor dressed, only a diaper and a simple "slip" or gown is put on and then it is warmly wrapped up and put in a little bed to itself. After twenty-four hours it is taken to the baby's bath room (which is properly heated) and there it is washed and dressed. Dr. Tyng, the physician in charge, tells us that since this plan has been adopted the babies get along much better. We were in the wards of this department about an hour, and during this time we did not hear a single cry from the babies. They all seemed contented and happy and were doing well. We are convinced that washing the child immediately after birth and keeping it half naked for a long time during the process of careful dressing, is not good practice.

CHARCOT'S JOINT DISEASE.—At a recent meeting of the Pathological Society (London *Lancet*, November 24, 1883), Dr. Hale White showed a pelvis taken from a subject which was brought into the Guy's dissecting-room last winter, and which he thought was an example of Charcot's disease. The bones were extremely thin and light, the spaces in the cancellous tissue being unusually large. This change made the bones so light that the whole pelvis weighed only seven ounces. The acetabula were much altered, the walls being as thin as paper in many parts. Owing to this tenuity of the bone, the heads of the femur had pressed the bottom of the acetabula into the pelvis, thus forming two very prominent bones in its interior, and making the transverse diameter of the brim three inches and a quarter. All articular cartilage had disappeared. This deepening of the cavity made its margins so very prominent, that the anterior superior spine quite overhung the acetabulum on the right side; at the back part the deepening was so extreme that the thick portion of the bone

between the acetabula and posterior surface of the ischium was almost worn through. On both sides, especially the right, it was seen that the deepened cavity was divided into two parts by a vertical ridge placed opposite the most superior part of the ischial tuberosity; the anterior of these two parts was for the lesser trochanter to play in, as the absorption of the neck of the femur was so great that the lesser trochanter was brought up to the margin of the obturator foramen. The chief points about the specimen were the great atrophy of bone without the formation of any new bone thus corresponding exactly to Professor Charcot's description of "considerable atrophy without the production of stalactites."—*Med. Record.*

TREATMENT OF TONSILLITIS.—Dr. Seiler, (*Med. News*), says:—The treatment of tonsillitis has of late been largely ventilated in the medical journals of this country and also in those abroad, and various remedies have been praised as specifics in this painful, and often recurrent, throat affection. Thus, for instance, a correspondent of the *Medical News* treats tonsillitis by the application of bicarbonate of soda, and claims that seldom are more than three applications of the dry drug necessary to cure even severe cases. There is no doubt that a mild alkali, such as the bicarbonate of sodium, is very soothing when applied to inflamed surfaces, and it is used largely in the treatment of burns on the skin, but in my experience it has failed to be more than a soothing application, and in spite of it many cases go on to suppuration. The same is true of the application of the gum-resins so highly recommended some time ago in this affection. I have not found anything better than a strong solution of nitrate of silver, sixty to one hundred and twenty grains to the ounce, applied with a brush to the inflamed glands; and, if the remedy is resorted to too early in the disease, the symptoms almost invariably subside within a few hours. If, however, the inflammation has lasted for a day or two, the silver-solution will not abort the attack, but it will in most instances prevent suppuration. It is curious to observe with what regularity in some persons the tonsillitis recurs during the winter months, and I have seen a number of cases in which a tonsillitis occurred regularly every six weeks. In these instances it is best to remove the glands, which are always more or less hypertrophied after an attack has passed off, either with the tonsillitome or, if the gland be too small to be grasped by the annular knife of the instrument, by a few incisions with the galvano-cautery knife.

TREATMENT OF DELIRIUM TREMENS.—In delirium tremens, nourishment is insisted on as of most importance by Dr. Atkinson in the *Practitioner*. Sedatives are useless unless the anæmic brain is supplied with nourishment, lack of which

causes want of sleep. The quality of the blood should be improved as rapidly as possible by easily digested food frequently supplied. Cut off all stimulants, order liquid essence of beef alternately every two hours, but with half a pint of milk. Chloral may be given every four hours, but will have no effect until the brain takes up some of the nourishment. Strong liquid food must be continued for several days. After ten or twelve hours of continuous sleep have been secured the chloral had better be discontinued and compound tincture of gentian, with tincture of nux vomica, given three times a day. Dupuytren employed small enemata, containing from six to ten drops of laudanum, in delirium tremens. If the first injection is rejected, a second and third may be required. If the calm is incomplete, an injection is given every six hours. The rectum absorbs and does not digest the medicine, which passes, therefore, more directly to its destination. Six drops of laudanum, in an injection, take more effect than fifteen drops given by the mouth; large quantities of opium are often swallowed by alcoholic patients without producing sleep. Besides, it is often difficult to get the subject of delirium tremens to swallow.—*Med. et Pharm. Belg.*

A NEW ANÆSTHETIC MIXTURE.—Dr. Rook, (*Four. of Am. Med. Associations*) refers to a new anæsthetic recently prepared by Dr. Wm. A. Byrd, Quincy, Ill., it is composed by measure—of bromide of ethyl, one part; chloroform, three parts; alcohol, four parts. These substances mixed, form a clear solution of a pleasant odor, and of a warm, sweetish taste. In the use of this anæsthetic, the stage of excitement or intoxication is brief, sometimes absent, and never violent. The stage of spasmodic rigidity of the voluntary muscles seldom occurs. Within a few moments from the commencement of the inhalation the stage of complete anæsthesia is induced.

The time to produce complete anæsthesia, is from one to three minutes in a child, and from three to five, and possibly eight minutes in an adult. When inhaled, and especially if inhaled through the nostrils, patients will sometimes complain of a choking or suffocating feeling, and sometimes, though very seldom, coughing will be caused, but it is quickly checked by pushing the anæsthetic a little faster.

The first effect upon the eyes is to dilate the pupils, but when complete anæsthesia is induced they are more or less contracted.

The first effect upon the circulation is to quicken the pulse, but when complete anæsthesia is induced, the pulse becomes slower, fuller and stronger.

The first effect upon the respiration is to stimulate it. But when insensibility is produced, it becomes slower, very much resembling the respira-

tion of natural sleep. The temperature is generally lowered, and occasionally, free perspiration occurs. In the administration of this anæsthetic, owing to the quantity of chloroform entering into its composition, a considerable amount of atmospheric air should be inhaled with it.

AN IMPROVEMENT IN THE METHOD OF USING THE FREEZING MICROTOME.—Mr. Sollas, in the last part of the *Quarterly Journal of Microscopical Science*, remarks that whilst the process of obtaining thin slices of soft structures by means of embedding in paraffin has been brought to great perfection, the freezing method still remains almost in its infancy. As a step in the improvement of this latter method he suggests that instead of freezing in gum, as is now generally practised, gelatine jelly should be used. This ought to be prepared and clarified in the ordinary manner, and should set in a stiff mass when cold. The tissue to be cut is transferred from water to the melted jelly, and should remain in it till well permeated. It is then placed on the piston of a Rutherford's microtome, and the "well" should not be filled; no more should be used than is sufficient to surround the specimen. When well frozen, slices may be cut in the ordinary way, and should at once be transferred to the glass slide on which they are to be mounted. A drop of glycerine must then be immediately added; a cover glass is then superposed; zinc white, or some similar cement is run round it, and the preparation is complete. In this way a series of entire slices of extreme thinness may be obtained from the most disconnected structures, even when they contain hard siliceous spicules, as in the case of sponges. Mr. Sollas states that diatoms may be cut without difficulty by this method.—*Lancet*.

DIET IN TUBERCULOSIS.—In the *Berliner Klin. Wochensh.*, No. 47, Dr. A. Bidder, of Berlin, concludes three articles on the relation between the alkalies of the food and the etiology of tuberculosis, by advocating a diet as free from potash salts as possible, but rich in common salt, as being a soda. He argues that the latter renders the tissues unfavorable to the development of the bacilli of tubercle, and that in young patients with tuberculous processes going on in the bones, joints, glands, lungs, etc., half a gramme of common salt should be given three or four times daily with the food, according to age. If dislike to this be shown, benzoate of soda may be substituted in doses of 0.2 to 0.5 gramme (3 to 7 grains). Indeed, the latter salt (known to be useful in the summer diarrhoea of children) is highly relished; it is aromatic in taste, and increases the appetite. Bidder thinks, moreover, that the well-known injurious influence of iodide of potassium upon tuberculosis or scrofulous processes is probably due not to the iodine, but to the potash, which is replaced by soda in the stomach. The

diet should contain an excess of albumen, of fat, and of salt in the cases mentioned. The article concludes by a reference to rickets, in which a connection with tuberculosis is attempted to be proved. Rickets is here said to be due to an excess of potash salts in the food as one cause of it.—*London Medical Record*.

DANGER OF ANÆSTHETICS IN KIDNEY DISEASE.—Dr. Turnbull dwells upon the great importance of attention to the condition of the kidneys and examination of the urine when an anæsthetic is to be administered. Many deaths, unaccountable otherwise, are due to this cause. In diseases of the kidneys, the blood being loaded with urea, anæsthetics almost invariably produce coma and death. He enumerates a considerable number of deaths from ether and hydrobromic ether, but very few from chloroform. Norris has reported two cases of death supervening unexpectedly from sulphuric ether after operations for cataract. Both recovered consciousness but died comatose, one in a few hours, the other after eighteen days; no organic lesion was found post mortem except Bright's disease. Cases have also been reported by Emmet, Hunt and Montgomery, verified by post mortem examination. The kidneys are the active agents in eliminating ether from the blood, and if they are unable to perform this office, and if the skin is cold, moist and inactive, death will supervene by accumulation of mucus in the lungs, or congestion of the brain, in true Bright's disease of the kidneys.—*Med. and Surg. Rep.*

ANOTHER ADVANCE IN ABDOMINAL SURGERY.—Mr. Nelson Dobbin, of Bristol, suggests the opening of the abdomen in cases of gastric ulcer where perforation has taken place. He advises, the stomach having been exposed, and the injury discovered, it should be treated in one of the following ways: either simply to stitch the viscus to the abdominal wall and establish a fistula; or, the edges of the ulcer being pared, to unite them by sutures or simply to sponge out the peritoneal cavity and leave all to nature. Of course, during either treatment, the patient's strength would be maintained by nutrient enemata. He has not yet practically tried his proposition. What led him to seriously consider the propriety of undertaking one of the steps he recommended, was a case he lately had of a young woman who, after a laborious day, was seized with pain and tenderness in the abdomen, followed by collapse and pain in the epigastrium. Death with symptoms of peritonitis took place in less than twenty-four hours. He was at the necropsy most strongly impressed by the ease with which the hole in the stomach could have been reached.—*Four. Am. Med. Association*.

AMPUTATION THROUGH JOINTS.—The dread which was formerly held of amputation at the

joints has even now by no means passed away. The disastrous results which follow wounds of the joints had long ago been noticed. In consequence, many hesitated to amputate through the larger joints, fearing the occurrence of like constitutional symptoms. And just here lies the error; the moment disarticulation is accomplished the joint loses its distinguishing characteristics. It is no longer a closed cavity; it is, in fact, no longer a joint, and is no longer subject to joint evils. The operation is a simple amputation, without the involvement of the medullary cavity, and without the many chances of osteo-myelitis. As to non-union of the parts dependent upon the presence of of articular and interarticular tissues, more careful investigation has shown that these structures soon pass away, usually by molecular disintegration and by separation, and that their final healing takes place, not less speedily, but probably more firmly and more safely, than in the case of an amputation in continuity.—*Med. World.*

POTT'S DISEASE OF THE SPINE IN VERY YOUNG CHILDREN.—As a substitute for the plaster-of-Paris jacket, Professor Hal C. Wyman has devised a method of treatment which presents many commendable features. It is substantially a movable jacket, and its application is briefly as follows: The child being placed in such position that the spine is extended to nearly the normal limit, a piece of cotton flannel large enough to cover, say one-third of the circumference of the trunk, is laid on the back. A sheet of absorbent cotton having been placed over this, a cheese-cloth bandage six inches wide and several yards long, with the meshes carefully filled with plaster-of-Paris, is dipped in water and folded lengthwise over the whole. When rubbed smooth with the hand so that it is perfectly adapted to the contour of the parts, a bandage is applied around the trunk, with figure-of-8 turns about the shoulders and pelvis, and the plaster allowed to set. The jacket thus constructed is in the form of a splint, and can be removed every night for the purpose of permitting massage.—*Medical Age.*

SULPHUROUS ACID IN MALIGNANT SCARLATINA.—In malignant scarlatina Dr. Keith Macdonald uses sulphurous acid. To a child ten minims of the acid in a little glycerine and water is given every two hours, and the acid (pure or diluted) is sprayed on the fauces a few minutes at a time every three hours. Also, sulphur is burnt in the room until the atmosphere begins to be unpleasant to breathe. This treatment was used successfully in about thirty cases by Mr. Jessop. Regarding the prophylactic power of belladonna in this disease, Mr. Owen Pritchard is convinced of its value. When a case of the disease occurred, he prescribed belladonna in one to three drop doses three times

daily to the remaining children in the same house who had never had scarlatina. Out of 74 children so treated, only four (5.4 per cent.) took the disease; while 36.2 per cent. of those not so treated contracted the disease.—*Med. World.*

SANTONINE FOR GLEET.—Dr. William Anderson thus writes to the *Lancet*: In treating a patient some months ago for lumbrici, he said to me "You have not only killed the worms, but you have cured my gleet." I may mention that the gleet had been obstinate, of long standing, and recurrent in spite of the usual remedies. He has had no return since. In 1864 I published a paper on santonine, but although I then made some experiments showing its effects upon the urine, it never occurred to me to try it in gleet or gonorrhœa. The formula I recommended is: Santonine, sacchari lactis, aa gr. v.; tere bene et ft. pulv. To be taken twice a day, fasting, in milk.—*Med. and Surg. Reporter.*

IODIDE OF POTASSIUM SEPARATELY.—"I shall give this patient twenty grains of iodide of potassium three times a day, and also one-twentieth of a grain of bichloride of mercury, with one grain of extract of cinchona three times a day, in the form of a pill. As you see I do not give iodide and mercury together. I direct a simple solution of the iodide to be made and the patient to take twenty grains in four ounces of water, three times a day, before meals, so as to secure its diffusion through the system before the mercury is administered. I think that it is always an error to combine these two remedies, for in such a combination you do not, as is commonly supposed, obtain the beneficial effect of both drugs."—*Bartholow.*

SYRUP OF DOVER'S POWDER.—The *Am. Jour. Pharm.* recommends the following:—

Deodorized tinct. of opium.....f. 3 viij.
Syrup of ipecac.....f. 3 x.
Simple syrup.....q. s. to make f. 3 lxxv.

Each fluid drachm contains one half grain each of opium and ipecac. The addition of potassium sulphate (discarded in the new officinal formula) would probably make the preparation no better.—*Louv. Med. News.*

THE ETIOLOGY OF PHTHISIS is expressed by a professor in Westminster Hospital College as follows (*Students' Medical Journal*):

Some are born to phthisis,
Some acquire phthisis, and some have
Phthisis thrust upon them.

Prof. Bartholow says that thymol is the best agent to destroy the odor of iodoform.

Prof. Da Costa recommends chloral hydrate in three-grain doses *ter die*, for infantile incontinence of urine.

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PUERPERAL FEVER.

Puerperal fever has come in for its share of the close inquiry so characteristic of the times. The disease did not escape the eagle eye of Hippocrates, yet the two thousand years and more which have elapsed since his day, have not sufficed to place it beyond the arena of conflicting views and heated disputations. Abnormal puerperal conditions must always remain subjects of the deepest interest and anxiety. The death of a beloved wife and mother is a great family calamity under any circumstance, but death in the puerperal state naturally evokes an unusual amount of sympathy, and subjects the unfortunate physician to a degree of adverse criticism that is sometimes appalling. Altogether the associated circumstances are such as to make the puerperal state one of far more than ordinary interest.

Even now, with all our boasted knowledge, it is no easy matter to formulate the predominant views of the day in regard to the nature of puerperal fever. The following quotations are from a paper recently read by Dr. J. Gaillard Thomas, of New York—"In regard to the pathology of the disease, he believed that puerperal fever, in whatever form it might show itself, was puerperal septicæmia; the cause of the affection being the absorption of a poison by a solution of continuity in the genital tract." In 1871 Hervieux had said:—"Here I stand . . . I believe in the multiplicity of puerperal diseases. I believe in their origin from puerperal poison." This aphorism he accepted as expressing his own views. Puerperal septicæmia

conveyed a clear and definite idea of the origin and nature of that affection. He thought that in spite of the fact that complications were of such frequent occurrence, the septic element was so paramount that the term should be adopted. Barnes had recommended the same, although he had adopted it with the proviso, that it did not indicate a distinct and specific poison. He himself however believed that there was a specific poison. In spite of every measure taken to prevent it, septic disease sometimes occurred. The poison might not be a necessarily specific one. It was probably the same as that giving rise to septicæmia after gun-shot wounds. . . . Whatever form the disease might ultimately take, whether cellulitis, phlebitis, peritonitis, or other variety of trouble, he could strike at the root by taking prompt action. . . . Although we did not know the exact nature of the poison, there could be no doubt that such poison did exist, and that there were only two methods by which it could be introduced into the system. These were, first, through the atmosphere, and, secondly, by the contact of the hands of the physician or nurse, or of clothing or bed-covering with the genital tract."

In one of the passages quoted Dr. Thomas says: "The poison might not be a necessarily specific one. It was probably the same as that giving rise to septicæmia after gun-shot wounds." How to reconcile this admission with his adoption at the outset of Hervieux's aphorism, which makes a separate and distinct poison, "puerperal poison," the cause of the disease, we leave to Dr. Thomas himself to explain. Notwithstanding this contradiction it is clear that Dr. Thomas believes that the disease may be induced by other than a distinct puerperal poison, but rejects the theory of self-inoculation by the absorption of putrid matter, denying that the disease so developed, however much it may simulate its symptoms, is true puerperal fever. In the discussion which followed the reading of Dr. Thomas' paper, Dr. W. M. Polk fully committed himself to the theory that puerperal fever is absolutely identical with surgical septicæmia and pyæmia. To what extent such views prevail it would be difficult to say; neither do we know to what extent it is believed that puerperal fever is not due to a hybrid poison but to a distinct and specific one, called puerperal poison. It is gratifying to know, however, that for

all practical purposes we may effectually raise ourselves above this region of doubt and perplexity.

It is conceded on all sides that the puerperal state is liable to take on numerous troubles (simple peritonitis for example) apart from any infectious or contagious influence. It is also pretty generally conceded that such diseases do not acquire the power to propagate themselves by infection or contagion. Almost equally general is the belief in the existence of a highly infectious and contagious disease known as puerperal fever—a disease which tracks the doctor on his rounds and enters every door imprudently opened to it—a disease the germs of which, whether simple or hybrid, meet in the puerperal woman a special susceptibility, a congenial soil. It is furthermore believed to be, in some way unexplained, associated with other diseases, as surgical septicæmia, erysipelas, and scarlatina, so that the lying-in woman is peculiarly liable to puerperal fever during the prevalence of these diseases.

From these established facts it is easy to draw some important lessons in obstetric practice. Reasoning by analogy, it is quite evident that the dangers besieging the puerperal state are to a very large extent within our control, and hence preventable. To reduce these dangers to a minimum, all that is necessary to do, is to surround the puerperal woman with the safeguards now so well known to medical and sanitary science. It is unnecessary to allude here to the personal precautions which, at all times, but more especially at times of unusual danger, should be observed by the medical attendant. These are well known and more or less practised by every prudent physician. In all cases firm contraction of the uterus should be obtained, for nothing is so productive of untoward conditions as a soft, patulous uterus. In difficult, or operative labors, more or less laceration and abrasion at different points is inevitable. These are open avenues through which the system may be poisoned. These avenues must be guarded by the use of appropriate treatment, from the beginning, particularly the use of disinfectant applications and injections. To be of any use injections must be repeated several times in the twenty-four hours. The most scrupulous cleanliness should be enjoined on the nurse, both as regards the patient and her own person. Were these precautions

more generally observed we should hear a good deal less about puerperal troubles. It is a most fortunate circumstance that the methods best calculated to prevent local disease are also the very best that can be adopted to ward off puerperal fever.

DOMINION HEALTH BUREAU.

A meeting of medical men and others interested in sanitary reform was recently held in Ottawa for the purpose of considering the question of establishing a Sanitary Bureau for the Dominion. Most of the professional members of the Senate and House of Commons and leading practitioners in Ottawa, were present. Dr. Bergin, M.P., acted as chairman and Dr. Playter secretary. A plan was proposed by the secretary and adopted, of which the following is a brief outline. It is similar in some respects to the plan proposed by Dr. Orton, M.P., a year or two ago. A good suggestion was also made by Dr. Hickey, M.P., viz., that certain members of the Senate and House of Commons be ex-officio members of the sanitary committee. The plan is as follows:—The Sanitary Bureau shall be connected with the Department of Agriculture, the minister thereof being minister of Public Health, in all matters relating to public health within the jurisdiction of the Federal authority, such as vital statistics, quarantine, etc. There shall also be a deputy minister or superintendent of the Sanitary Bureau, the same to be a medical man appointed by the Government, and who shall be the chief sanitary officer. There shall be a permanent sanitary committee associated with the Sanitary Bureau, which shall consider and discuss all matters coming within the province of the bureau, and all matters pertaining to the public health of the Dominion, and which shall also confer with and advise the minister and chief sanitary officer in all such matters, and consider what legislation, provincial and federal, will best promote the public health. The Sanitary Committee shall be composed of at least one member from each of the principal Provinces, and the chairman and secretary shall be appointed by the Government; the minister and deputy or superintendent of the Sanitary Bureau shall be ex-officio members of the Sanitary Committee. The committee shall meet at certain times in the year in Ottawa for the consideration of matters relating to the public health.

of the Dominion. The chief sanitary officer and the secretary of the Sanitary Committee shall receive a salary, but the other members of the committee only travelling expenses and a per diem honorarium while engaged on the duties of the Board. There shall be appointed by the Government in various localities throughout the Dominion a number of local sanitary officers, who shall be medical practitioners, and who with the committee and officers before above named shall constitute the sanitary staff of the Dominion. Every local sanitary officer shall send to the department at Ottawa, on the first day of every month, a report or statement of the nature or kind, extent and course, so far as can be by him obtained, of any epidemic or epidemics of infectious disease that have prevailed in his locality during the previous month, and such information concerning the general condition of the public health therein as he may be able to obtain, or as may be determined upon by the Sanitary Committee; each local sanitary officer shall be paid for each and every such report or statement the sum of \$2. As the present system for the collection of mortuary statistics is enlarged from time to time, these local sanitary officers may become the statistical officers of their respective localities for making correct returns of deaths to the department. On the outbreak of any epidemic of infectious disease in any locality, the local sanitary officer of such locality may, at the request of the chief sanitary officer, make investigations into the source, origin or cause of such outbreak. The department shall issue for free distribution, early in each month, a report containing a synopsis of the reports received from all the local sanitary officers, and any other sanitary information or the public that may be deemed advisable by the committee; and it shall also issue an annual report. The probable cost of the whole system per year will be about \$10,000 or \$11,000, which is indeed a very moderate sum for a Dominion Health Bureau. The plan seems feasible and has much to commend it. We trust its promoters may be successful in carrying it through.

ONTARIO HEALTH ACT.

The amendments to the "Ontario Health Act" which were introduced during the recent session of the Local Legislature have now become law. The revised act places in the hands of local or district

Boards of Health the powers which have hitherto belonged to the municipalities. The local boards shall consist of the Mayor or Reeve, the Clerk, and from three to six ratepayers according to the size of the municipality, appointed annually by the municipal council; and the district boards of the mayor or reeve, the clerk and one ratepayer appointed by the council. The members of these boards are constituted Health officers with full powers, within the meaning of the "Revised Statutes respecting Public Health," in addition to those under the present act. It will be the duty of the Boards of Health, from time to time, to cause inspections to be made of their respective districts with the view to the removal of any accumulations of matter offensive and likely to have an injurious effect on the public health, to investigate all complaints regarding nuisances, and to take such action as may seem advisable. Local Boards shall have the same power and authority as Justices of the Peace to compel the attendance of witnesses, and secure evidence.

A somewhat arbitrary clause has been enacted, making it obligatory upon the council of any city, town or village, proposing to establish a public water supply, or system of sewerage, to communicate with the Provincial Board of Health on the subject, and submit their plans for its approval, as no drain or sewer can be constructed in violation of any of the principles laid down by the Provincial Board of Health. The Local and District Boards cannot but feel slighted at this usurpation of power. Surely if they are competent to deal with other and equally important duties they might also be allowed to determine the matter of water supply and sewerage in regard to which, being on the spot, they should be as competent to decide as the Provincial Board in its meetings in Toronto.

The duties of health officers, house holders and others in the case of infectious diseases are fully defined, and provision is made for the imposition and recovery of penalties liable to be incurred through infraction of the law.

KINGSTON MEDICAL COLLEGE.—The following is the list of graduates and honor men at the recent examinations:

Graduates:—R. N. Fraser, Westmeath, *Gold Medallist*; C. G. McCammon, Gananoque, *Silver*

Medallist; E. Beatty, Lansdowne; W. H. Bulles, Chatham; R. C. Cartwright, Kingston; H. R. Duff, Kingston; T. Cumberland, Rosemont; J. Ellery, Dresden; E. Forrester, Mallorytown; E. Foxton, Kingston; A. Forin, Belleville; J. Herald, Dundas; A. McGillivray, Washburn; E. E. Smith, Winona; J. E. Stirling, Kingston; W. J. Webster, Napanee; H. S. Williams, Picton.

Primary.—W. C. Beaman, H. Burdett, J. Caselman, C. Collins, W. F. Coy, M. L. Dickson, (honours), A. A. Dame, D. E. Foley, (honours), T. D. Galligan, G. J. Jack, A. Jamieson, W. M. Mather, E. J. McCardel, S. J. Mellow, A. F. McVeitty, F. B. Smith, D. A. Storms, A. N. White, E. W. Wright.

Intermediate.—T. H. Bertram, W. C. D. Clark, H. C. Cunningham, A. Dwyer, H. B. Ford, W. A. Kyle, J. A. Stirling, F. E. Hooper, H. Roy, W. Spankie;—Dawson, Corlis, and Smith.

Hospital House Surgeons.—J. E. Stirling and D. J. Russell, Cheboygan.

Demonstrators of Anatomy.—W. A. Kyle, Winchester, third year; M. L. Dickson, Frankville, second year. Prize of \$25, A. Dwyer.

DIGITALIS IN DROPSY FROM HEART FAILURE.

—In the *Can. Med. and Surg. Jour.* for January, 1884, Dr. Ross reports two cases of dropsy from heart failure, which show, in an unmistakable manner, the value of digitalis in the treatment. In one of the cases the patient was relieved on three different occasions from impending danger by timely doses of tincture of digitalis, in from five to ten minim doses. In the other case, one drachm of the infusion of digitalis, combined with fifteen grains of bitartrate of potash and ten minims of spirits of chloroform, were administered with excellent results. The infusion of digitalis, freshly prepared, is preferred by many to any other form in such cases as above mentioned. An article appeared recently in the *LANCET* by Dr. Jas. Braithwaite, strongly recommending the infusion.

CANADA MEDICAL ASSOCIATION.—We have been requested by the General Secretary, Dr. Osler, to state that the President and Local Committee have decided that the meeting of the Association shall take place in Montreal on the 25th, 26th and 27th of August. The meeting of the British Association for the Advancement of Science begins on the

27th, so that members will have an opportunity of remaining over to see the leading scientific men of Great Britain. Some of the members are medical men, and they are expected to join in the proceedings of the Association.

INHALATION FOR CATARRH, ASTHMA, &c.—The following formula is recommended in the *Four. de Med.*, Paris, by M. St. Martin:

R	Acid carbol.....	5 grammes.
	Liq. amm pur.	6 "
	Aquæ dest.....	10 "
	Alcohol.....	15 " M.

Sig.—Saturate cotton wool with the solution, and breathe the vapor from a wide-mouthed bottle, or use the mixture in an inhaler.

PERSONAL—Dr. Carroll, U. S. Consul, at St. Thomas, Ont., was presented with an address and a gold-headed cane as a mark of esteem by his personal friends previous to his departure for Italy, where he has received an appointment under the U. S. Government.

Dr. Osler, of Montreal, sailed on the 25th ult. for Germany, and will be absent until the middle of August.

IODIA IN SYPHILIS.—Dr. C. A. BRYCE, *Southern Clinic*, says: "He has had the most gratifying experience with IODIA in Syphilis. He has treated many hundreds of cases with it, and regards it as the best preparation he has ever used for constitutional syphilis, after the moderate use of mercury. He generally uses it in all cases of syphilis in the final treatment.

ARE YOU GOING TO EUROPE?—In another column will be found the announcement of Messrs Thos. Cook & Son, Tourist Agents, 261 Broadway New York, relative to the very complete arrangement they have made for tours in Europe the coming Spring and Summer. "Cook's Excursionist," will be mailed to any address on receipt of 10 cents.

APPOINTMENTS.—James Neish, M. D., health officer at Port Royal, Jamaica, formerly of Kingston, Ont., has been appointed garrison surgeon at Port Royal, with salary of £100, in addition to the duties at the quarantine station, with a salary of £500. Dr. Douglass has been appointed I

cense Inspector for the County of Bruce, and Dr. Worthington for the County of Huron.

OBITUARY. — Dr. Alexander Wood, of Edinburgh, died on the 26th of February. To him the profession is indebted for the introduction of the hypodermic injection of drugs by the hollow needle syringe.

SET AT LIBERTY.—Dr. Griffith, formerly of Fergus, who, it will be remembered was sentenced to three year's imprisonment in the Kingston Penitentiary for bigamy, has been set at liberty.

Books and Pamphlets.

TRANSACTIONS OF THE VACCINATION ENQUIRY. Part I. Edited by Montague D. Makuna, M. R.C.S., Eng.; L.R.C.P., London, etc., etc. Published by W. H. Lead, Leicester.

This is an invaluable publication, and its appearance at the present time, when so much worse than vapid nonsense has been spread amongst defectively informed communities, in both the old world and the new, must be regarded as most opportune. The committee of enquiry, under whose auspices the work has been brought out, consists in all of thirty members, twenty-two of whom are experienced medical practitioners, and eight are public vaccinators, officers of health and private gentlemen. The labour of compilation, which must have been one requiring extraordinary energy and exhaustless patience, has been performed by the editor with commendable efficiency. "Seven circular questions" were addressed to medical practitioners in England, Ireland and Scotland. The replies received from 384 are given in the publication in parallel columns, headed by the respective questions. The following are the questions submitted:—1st. What are your views regarding compulsory vaccination in England, Scotland or Ireland? 2nd. What are your views regarding the protection afforded by vaccination against small-pox? 3rd. What diseases have you, in your experience, known to be conveyed, or occasioned, or intensified by vaccination? 4th. What opinion do you hold as to the quantity and quality of vaccination, as determined by the cicatrices? 5th. What opinion do you hold as to the relative values of humanised and

animal lymph, both as regards efficacy and safety? 6th. What opinion do you hold regarding the relations subsisting between variola and vaccinia, and the theory of vaccination? 7th. How far do you consider insanitary conditions responsible for small-pox epidemics, and how far can small-pox be controlled by improved sanitation?"

To introduce here illustrative specimens of the answers furnished, or even to attempt any instructive analysis of their multitudinous contents, would be an undertaking alike unsuited to our capabilities and to the space at our command. Besides, the opinions expressed by the very great majority of the 384 respondents are so perfectly concurrent with those entertained by almost the entire body of the medical profession in Canada, that their reproduction in this country would be almost a work of supererogation. On the first question, as to the advisability of compulsory vaccination, there is a large affirmative preponderance. The like may be said as to the answers to the second question, with certain very judicious conditions introduced. The replies to the third question intimate exceptional morbid results, such as are well known to observant practitioners in America, but their occurrence is so infrequent, and with due precaution so easy of avoidance, that no conclusion adverse to vaccination can be drawn from them. The fourth question has elicited various opinions, as to the number of points of vaccination, some respondents demanding as many as six, some four, perhaps a majority three, whilst a few ask for only one. To the fifth question the majority reply in favour of animal lymph, but a respectable minority regard the choice as indifferent, and a few prefer the human lymph, provided due care is taken as to the constitutional soundness of the children from whom it is taken. The sixth question, as it involves theoretical discussions, has been answered variously, according perhaps to the preconceptions of the writers, some of whom assert their belief in the identity of vaccination and variola, whilst others insist on their specific difference, and a considerable number regard the former as a modification of the latter. To the seventh question the replies seem to have been pretty harmonious. Insanitary conditions aggravate small-pox epidemics, but *per se* they do not cause the disease; a fact which undoubtedly applies to all other contagious diseases.

It would be unjust to one of the 384 respondents, J. Mackenzie, M.D., F.R.C.P., who hails from Inverness, to pass over unnoticed his smashing replies; and as they are as short as they are pithy, we give them, in *ipsissimis verbis*: To the 1st question Dr. M. replies: "It (vaccination) ought to be speedily given up." To the 2nd; "No protection whatever, rather the contrary from injuring natural health." To the 3rd; "Eczema in an infant after vaccination, scrofula in four cases where no hereditary taint existed." The 4th, 5th, and 6th questions would seem to have been regarded by Dr. Mackenzie as too contemptible for his august consideration; and accordingly he has not condescended to notice them. His answer to the 7th would appear to indicate that he is not an unbeliever in the millenium, or that he expects to catch some larks when the sky falls. Here it is: "Will be a rare disease indeed when people live on sanitary rules." Verily, if small-pox will not die out until "people live on sanitary rules," we rather surmise that the malady will be very long-lived. Apropos of these "sanitary rules," we would very much like to know whether Dr. M.'s four subjects who, as he says, contracted scrofula from having been vaccinated, had always enjoyed the benefit of "sanitary rules." We should also desire to learn the extent of Dr. M.'s enquiries as to the absence of "hereditary taint," in the said "four cases." Enquiries of this sort, we all know, are of a delicate nature, and the replies of relatives are often very unreliable. Besides, the research is too usually performed in a very perfunctory manner. If Dr. M. is a young man we would advise him to try to learn more. If he is old, he will jog on, and rejoice in his lofty-pacing ignorance.

INFLUENCE OF THE MIND UPON THE BODY IN HEALTH AND DISEASE. By Daniel H. Tuke, M.D., F.R.C.P., LL.D., etc. Second American from the second English edition. Philadelphia: Henry C. Lea's Son & Co. Toronto: Hart & Co.

The venerated name *Tuke* should be a sufficient passport to any psychological work bearing this imprint. It is very gratifying to see that the American publishers have found this book so much sought after as to call for a second edition; but we do not wonder that it has been so much appreciated on both sides of the Atlantic, for it is not only a very instructive, but even a wonderfully amusing

book, considering, especially, that the author is, or ought to be, a member of the brotherhood of the *Friends*. Everybody knows that old Burton's "Anatomy of Melancholy" is well worth many readings, for the mere sake of the abundance of its quaint mediæval Latin quotations, some of which are however less pleasing to modern ears than they were to those of our forefathers, and mothers' eke, 250 years ago. Dr. Tuke's book is not so densely spiced with poetry as Burton's was, yet it contains some very fine samples from our best English poets, pleasingly and fittingly interposed here and there throughout its pages. He has not altogether shunned the Latins; yet he draws on his classic treasury only just enough to satisfy the reader that he still has a fair balance at his command. Like a sensible plain Englishman, he has found in Spenser, Shakespeare and Milton, almost all that he deemed pertinently illustrative of his subjects. No library should be without this book, and it may be read with both profit and pleasure by men and women, boys and girls, deacons and doctors.

HISTORY OF TUBERCULOSIS. By Dr. Arnold Spina, Translated from the German by Eric E. Sattler, M.D., Cincinnati.

This little book of 184 pages is printed in very plain type, on strong paper. It purports to be "A history of Tuberculosis, from the time of Sylvius to the present day," and it also contains "an account of the researches and discoveries of Dr. Robert Koch and other recent investigators." The characteristic bibliographic zeal of his countrymen is abundantly exemplified by Dr. Spina, in the multitudinous citations from both old and recent writers, which he has introduced. Nearly two hundred authors have been quoted, so that both the medical neophyte, who may not have become intimate with more than one or two authorities, and the long experienced savant who has been bewildered by the contraries of dozens, and has probably, and it may be fortunately, forgotten the whole of them, may, in this compendium, rehabilitate himself in the literature of Tuberculosis, with the least possible expenditure of time and patience.

Decidedly the most instructive portion of the book will be found in the final fifty-six pages, which are devoted to the discussion of Koch's investigations, which have been scrutinized by Spina in no very commendatory terms. Koch is, of course,

quite able to maintain the integrity of his bantering germ, but he certainly has in Spina no feeble antagonist.

HEALTH RESORTS—San Remo and the Western Riviera climatically and medically considered. By Arthur Hill Hassall, M.D. Lond., M.R.C.P. Eng. London: Longmans, Green & Co.

For health seekers from our Dominion who are favored with both abundant means and leisure, no more interesting guide book to that delightful resort lying between Cannes and San Remo, a space which includes a sea frontage on the Mediterranean of fifty miles, could have been furnished. In this small area lie the world-renowned health resorts of Cannes, Nice, Monte Carlo, Mentone, Bordighera, and San Remo, sheltered by protecting hills and mountains. Behind these mountains lie the Maritime Alps, reaching an altitude of some 7,000 or 8,000 feet, beginning at Nice and extending as far as Genoa, where the Apennines commence. These resorts are triply protected, by the olive-clad hills, by the mountains next in order, and by the Maritime and Ligurian Alps, acting as ramparts against the northerly winds. The mean temperature from November to April, is 52.8; mean humidity of same winter season, 68.9. This very interesting work of Dr. Hassall is divided into five chapters:—1st. Situation, water-supply, drainage, walks, drives, amusements. 2nd. Food supplies. 3rd. Geology, prevailing winds, sun heat, duration of days of warmth. 4th. Characteristic vegetation of the Riviera. 5th. Effects of climate on functions of the body. Results of treatment of consumption and other diseases. The advantages of the Riviera for consumptives in whom the disease is at an early stage, may perhaps in some measure be stated as resembling the picture of an Atlantis so well drawn by Dr. Richardson: "It should be near the sea coast and sheltered from northerly winds, the soil should be dry, the drinking water pure, the mean temperature about 60° Fahr., with a range of not more than 10° or 15° on either side." To all on this side of the Atlantic contemplating a search after health in European resorts, we would recommend a perusal of this excellent work by Dr. Hassall.

MANUAL OF PRACTICAL HYGIENE—Parkes. By Dr. Chaumont. Second volume. New York: Wm. Wood & Co. Toronto: Williamson & Co.

In this the sixth edition of this most comprehen-

sive and valuable work considerable additions, illustrating the advance of the science of Hygiene, have been made and a very excellent American Appendix to the volume attached. An interesting account will here be found of the various State Boards of Health that within the last twenty years have from time to time been established—at the present time twenty-nine in number; of the great work accomplished by these Boards in spreading accurate knowledge concerning the causes of disease and methods for its prevention, and of the great advance that has been made in the collection of Vital Statistics; also very admirable treatises on water, soil, climatology and meteorology, ventilation and warming, removal of house waste, food adulterations, and hints to sanitary inspectors. This edition by Dr. Parkes should grace the shelves of every practitioner of medicine.

BRIGHT'S DISEASE OF THE KIDNEYS. By Henry B. Millard, M.D., M.A., with numerous illustrations. New York: W. Wood & Co.

This is another book of commendable brevity. It contains, in less than 240 large type pages, 25 chapters, illustrated by 24 attractive representations of kidney disease. The author has written as one who not only "has the courage of his opinions," but also as one who, in desirable addition, possesses the faculty of expressing them in clear language, and in a style well deserving of imitation by not a few of the fast bookmakers of this continent. Nor is he afraid to step outside the columns of stereotyped English lexicography, when necessity or fancy calls for the coining of a new word. Why should we not introduce new vocables? Surely our language has been, and should continue to be, a thing of continuous growth. It did not shrink into petrification in the times of Chaucer, Spencer, and Shakespeare, nor even in those of Milton, Addison and McAuley. It must obey the imperative law of evolution, despite all the fetters of the Johnsons, Websters and Worcesters in or out of christendom. We most heartily welcome Dr. Millard's contributions of such words as "causology," "lentescent," and "junctional." To ridicule them as rude innovations, would be the very acme of pedantry. More strength to his elbow say we; and we shall long to see more samples of his useful manufacturing.

PRACTICAL PATHOLOGY FOR STUDENTS AND PRACTITIONERS. By G. Sims Woodhead, M.D., F.R.C.P.E., Pathologist in the University of Edin-

burgh, with 136 colored plates. Philadelphia : H. C. Lea's, Son & Co. Toronto : Hart & Co.

The object of the work has been to supply a guide to the study and examination of morbid tissues, and this the author has accomplished in a most complete and satisfactory manner. The first two chapters contain full and complete instruction for preparing, staining, and mounting specimens. The following chapters are devoted to the various pathological conditions of the liver, heart, lungs, blood-vessels, kidneys, spleen, nervous system, tumors, parasites, etc., etc. The plan adopted is to follow the tissue from the body to the microscope, to describe the method of making macroscopic and microscopic investigation, to indicate the more important pathological changes of each organ, and to describe the more important lesions. The colored illustrations are most beautifully executed, and reflect the highest credit upon the artist. Upon the whole, the work is one that we can unhesitatingly recommend to the profession in Canada.

THE INTERNATIONAL ENCYCLOPÆDIA OF SURGERY. By authors of various nations. Edited by John Ashhurst, jr., M.D., Philadelphia; in six volumes. Illustrated with chromo-lithographs and wood-cuts. Vol. IV.. New York : Wm. Wood & Co., 1884. Toronto : Hart & Co.

Three volumes of this admirable Encyclopædia of Surgery have already been most favorably noticed in these columns. We have only to add that this volume fully warrants the favorable opinion previously expressed. If we might make comparisons as to the character and value of each volume we would say that this is the best which has as yet appeared. The articles contained in the 4th volume are as follows :—Injuries of bones—Packard ; Diseases of joints—Barwell ; Excisions and resections—Ashhurst and Fenwick, (Montreal) ; Tumors—Bublin ; Injuries of the spine—Liddell ; Diseases of the spine—Treves. The article on injuries of the spine possesses the melancholy interest of being a posthumous contribution from the pen of the late Dr. Liddell, who died almost as the last proof-sheets were being corrected.

HEALTH AND HOME, a journal of Sanitary Science, and Home Hygiene. Edited by F. N. Boxer, C. E., Montreal, Que. Price \$2.

We have received the first number of this new monthly, which makes fair promise of future usefulness in the department of sanitary science. The object of the publication as stated by the editor is "the promotion of sanitary education in homes and schools, and the diffusion of sanitary know-

ledge to all classes." As such we have no doubt, if properly supported, it will contribute its share in the great work of educating the masses in sanitary science and domestic hygiene. Some of the defects incident to maiden efforts of this kind are observable in its pages, but future issues will no doubt be an improvement upon the present, which, upon the whole, is very creditable.

JOHN THOMSON, M.R.C.S.E.

We regret to record in this issue the death of Dr. John Thomson, of Chatham, N.B., at the ripe age of 75 years ; one of our oldest physicians, and one whose career has been remarkable for its length, activity and usefulness. He was born in Perthshire, Scotland, in 1808, and came out to Miramichi with his parents in 1816. After a course of study with Dr. Key, he went to Edinburgh in 1828, and received his degree of M.R.C.S.E. Returning to his home in 1833, he commenced practice at Newcastle, N. B. Soon after he was appointed surgeon to the small-pox hospital in Chatham, and was subsequently placed in charge of the quarantined crew and passengers of the ill-fated "Loo-stock," most of whom died of that disease in its most virulent type. Appointed to the superintendancy of the Government Marine Hospital, he held it for 53 years ; also of the County Alms House in 1869, which he held until his last sickness.

He was a man of unswerving integrity, most prompt and faithful in the discharge of his many duties, honorable in his intercourse with his medical brethren, and courteous to all. For 36 years he held a leading place as elder in the St. John Presbyterian Church, where he will be greatly missed. He was beloved by his patients and revered and honored by all.

Births, Marriages and Deaths.

In Peterborough, Ont., on the 26th of February Dr. J. F. O'Shea, to Miss Minnie Henry.

At Walkerton, on the 18th of February, the wife of Dr. M. Stalker, of a son.

At Wickham, N. B., on the 17th of February Robt. Black, M. D., aged 81 years.

In Halifax, N. S., on the 14th ult., Dr Clay, aged 62 years.

*** The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

THE CANADA LANCET.

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Original Communications.

CASE OF INTERSTITIAL FIBROID TUMORS OF THE UTERUS.

BY JAMES FERGUSON, M.D., CUMBERLAND, ONT.

On the 18th August, 1882, I was called to see Mrs. McD., aged 42, married 13 years; never had any family; never had been pregnant. Found her suffering severe pain and in great distress from swelling or "hard lumps," as she called them, in her bowels. She described her pain as excruciating, preventing her from sleeping, taking away her strength and unfitting her for work. She looked the picture of anxiety and distress. I elicited the following as to her previous history. From a girl had always painful menstruation, habitually constipated, and suffered much from wind in bowels, otherwise had good health; never any severe sickness, and was until a few days ago able to look after the house and dairy work of a large farm; had been a hard worker, and in harvest time would pitch grain and help generally at field-work. For two years previous had felt more or less dragging-down pains and sense of fulness in lower part of abdomen, but never experienced any great inconvenience apart from her usual dysmenorrhœa until last June last when she felt a hard lump just above the pelvis. This rapidly increased. In the two and one-half months which had elapsed from the time she first felt it until I saw her on 18th August, she had enlarged to the size usually attained in a case of utero-gestation at the fifth or sixth month. She had been examined by a physician who pronounced her case ovarian tumor, and advised her to go to Montreal and have it operated on. Before doing this, her husband sought my advice, and on examination I found her as before stated, areworn, and in much suffering, but not presenting the "facies ovariana" so characteristic of ova-

rian tumor. On passing my hand over the abdomen with slight pressure with the finger, I could easily make out at least three distinct, hard, unyielding, uneven knob-like masses, tender to touch, perfectly free from fluctuation and not moveable, but greatly distending the abdomen; no tympanitis. The abdomen though much distended was unevenly so, the bulk of the protuberance being above and to the left of the umbilicus per vaginam. I felt for the os uteri but could not find it digitally, and with my speculum succeeded no better; ordered her to remain quiet in bed, (up to this time she had been going about every day when able), and on no condition to leave it till I saw her again; gave her morphia and bromides, to relieve pain, and a good diuretic for the dysuria which was now troublesome, and left her. Returned on third day and succeeded in finding the os which was tilted back; when brought into the field of vision it looked healthy but small as a virgin's, hard, rigid and unyielding, and although I tried with patience and perseverance, I could not introduce the sound into the cavity of the uterus. Fearing that I might have a case of fibroid polypus to deal with, I did not use extra force with the sound, but as the rest and quiet with the soothing treatment, had had the desired effect in controlling pain, I left her on the same, adding, thereto a mixture of sulph. mag., bi-tart. potas, and tr. ferri to be taken every second or third morning as required. By the middle of September, under a tonic and supporting treatment, she had gained some strength. I repeated my attempt to introduce the sound, and with some trouble succeeded, when I found the uterus slightly anteverted, and elongated to the capacity of three and a-half inches, and the cavity of the womb pressed upon by hard resisting tissue on each side. I could detect no polypus or intra-uterine fibroid, and satisfied myself that the tumors were not *inside* the womb. That they were not ovarian I inferred from the hard, rigid, almost bone-like feeling, and the entire absence of any fluctuation in and the immobility of the mass—it could not be polypus as there was an almost total absence of bleeding after my prolonged use of the sound inside the womb; but the rapid growth which had taken place in two and one-half months, together with the great pain experienced, left me in doubt as to the benign or malignant character of the tumor

which I now diagnosed to be in the walls of the uterus. As Mrs. McD. had suffered so much and so long from dysmenorrhœa, I continued the dilatation of the os uteri until I satisfied myself that the canal of the cervix was sufficiently enlarged to allow of the free flow of the menstrual discharge which had always been painful and prolonged, and a time by her much dreaded. I pursued the method laid down by the late Dr. Sir J. Y. Simpson, of Edinburgh, and the sequel proved the correctness of the course adopted, as she menstruated on the 18th to 20th of same month, September, 1882, and under the influence of a pill or two of henbane and belladonna, with the bromides she passed through the period with unwonted ease and comfort—still kept her quiet and in recumbent position, on general supporting treatment, never being able to suspend the bromides or morphia. She became fairly comfortable. Although I had diagnosed fibroid tumors of the walls of the uterus yet, fearing from the rapid growth of the mass and the unceasing character of the pains in the tumors, that they might be malignant, I determined on a consultation, and on the 7th of October Dr. Trenholme, of Montreal, who has made a specialty of diseases of women, saw Mrs. McD. with me. To our intense surprise we found it impossible to introduce the sound, and had to be satisfied with what knowledge we could gain without this valuable aid to diagnosis. Dr. Trenholme agreed with me that the tumors were not ovarian, but fibroid, and counselled non-interference and the expectant treatment. The relief which our patient experienced when informed that no operation would be required, was very marked. With great care, good nursing and attending to symptoms as they arose, she passed along fairly well until the middle of February, 1883, but on the 26th of that month I found her in great pain, much swollen, feverish, with severe nausea, vomiting and considerable prostration; she had not menstruated but once after I dilated the os uteri, and thought she felt something moving within her, but as she was forty-two years old, and never had been pregnant, I supposed her sensation was due to flatus, and never for a moment suspected that she was pregnant. I satisfied myself, and relieved my patient with appropriate treatment; bismuth and ingluvin were freely used to check the vomiting, and acted like a charm. On 18th March my

attention having been called by my patient to the fact of her having milk in her breasts, the enlargement of the glands, the dark areola around the nipples, the general embonpoint of the woman, the suppression of the menses and her assurance that she felt something moving in her, led to a suspicion that she might be enciente, and a careful examination with the stethoscope detected the sounds of the foetal heart distinctly though feebly, to the right and just below the umbilicus—the double sounds or the “tic tacs” of the foetal heart beating one hundred and thirty while the pulse of the mother was only eighty per minute, was the conclusive and absolutely sure ground on which my diagnosis of pregnancy was made—and the intelligence of the fact, which seemed so impossible a few months before, pleased my patient wonderfully. From this time until the middle of June following, she passed most of her time in bed, fairly comfortable. Some dyspnœa, when she sat up in a chair, considerable swelling of the feet and legs, and the fact that the tumor no longer increased in size, were the only noteworthy features until the 19th June, 1883, when I was called to see her and learned that she had had regular bearing down pains from four o'clock that morning. On examination I found the os dilating and labor fully established, the pains being slow, and her strength equal to the tax upon it. I did not hasten labor further than dilating the rigid os from time to time with my fingers, and at two a.m. on the morning of the 20th of June, I delivered her of a living child, girl, feet presentation, and not one ounce of liquor amnii or blood either before or after delivery; child weighed three and a-half pounds, fully developed and at full term. On attempting to remove the placenta the cord separated from its connection therewith, came away in my hand on the slightest traction, and left the entire after-birth in utero. That which under ordinary circumstances I would not have dared, I was obliged to do as the uterus was inert and quite unable to expel its contents; oiling my arm, I carefully introduced my hand into the womb, seized the placenta which was small but very high up above the umbilicus, and not without some difficulty removed it, at same time taking advantage of the chance, with one hand in the uterus the other on the outside of the abdomen, I ascertained the size, character and position of the tumor. The cavity of the

uterus was very small, just room for my hand to turn round in ; walls very hard and thick ; between my hands I could feel three large, and several small lumps, one on the left side as large as an adult head, the other on the right side, and at the base of the womb, about the size of a child's head at birth, the others smaller. The entire walls of the uterus were excessively hypertrophied, and after birth of child and removal of placenta I could see no appreciable diminution in the size of the abdomen, bandaged, gave mild stimulants and watched with her until seven o'clock, and left mother and child wonderfully well. She made a very good recovery, and in one month was able to move around her house freely.

Friday, 20th March, 1884. Just nine months since her confinement, Mrs. McD. presents the appearance of good health, is strong, able to do house-work, has only an occasional pain and that trifling, and on palpating over the abdomen hardly the slightest trace can be felt—just above the brim of the pelvis—of those terribly painful and rapid growing tumors which eighteen months ago seemed so unlikely of such a cure. Mrs. McD. still nurses her child and has abundance of milk; child is very healthy, weighs fourteen pounds. She still takes the saline and ferruginous mixture which I put her on nearly two years ago.

This has been a deeply interesting case to me, and in hopes that it may not be void of interest to the profession at large, I submit it through the "LANCET," to my medical brethren for the consideration of what I believe are the chief features of importance in it, viz. :—

I. The rapid growth and intense pain of these fibroid tumors—growth being generally very slow.

II. The effect of free dilatation of the cervix uteri in the case of sterility at the age of forty-two years, followed immediately after by conception.

III. The tenacity with which the uterus retained the child during the full term of utero-gestation, while its walls were the seat of such large abdominal growths, and the cavity of the womb so much impinged upon.

IV. The gratifying result here seen of pregnancy on the diseased tissues of the uterine walls—1st, by arrest of development during utero-gestation, and 2nd, the nearly total absorption of the hypertrophy in the uterus taking place nine month's after child-birth.

TWO CASES OF LAPAROTOMY BY DR. T. GAILLARD THOMAS.

BY A. SANFORD, M.D., BURLINGTON, N. S.

CASE I.—Miss Sarah W., æt. 32, menstruation irregular, duration seven days, scanty, very painful, especially before the flow, and a constant sufferer from pain in the back and legs, and headaches.

Diagnosis.—Anteflexion—prolapsed ovaries.

Treatment.—An incision was made in the median line down to the peritoneum, which was carefully opened with scissors ; the ovaries were readily found and ligatures of carbolized silk were tightly applied. The ovaries were then removed, the cavity carefully sponged out and the wound closed by interrupted wire sutures embracing the peritoneum. The operation was completed in thirteen minutes. The ovaries were found in the condition known as apoplectic or enlarged by blood cysts.

Remarks by Prof. Thomas.—Great care should be used in applying the ligatures ; unless properly done hemorrhage will follow and prove fatal. When searching for the peritoneum, (which in this case was hard to find), if great care is not exercised in opening it the intestine is likely to be wounded, and would prove a terrible calamity to the patient.

CASE II.—Mrs Kattarina A, aged 37, married 15 years, no children nor miscarriages, menstruation regular, amount normal—pain before and during flow, constant pain in the abdomen, back and head. Tumors of two years' growth commencing in the left side, causing vesical irritation and pressure on rectum.

Diagnosis.—Uterine fibroid.

Treatment.—Removal of ovaries—operationsame as before; the Prof. explaining the method of applying and knotting the ligature to avoid hemorrhage. The carbolized silk will be absorbed and cause no trouble. When the fibroid came in view Dr. T. remarked that its removal would be a very serious affair and wholly unnecessary, as it would soon atrophy after the cessation of menstruation following the removal of the ovaries. The operation was completed in 11 minutes.

Dr. Thomas is the well-known Prof. of Gynecology in the Coll. Phys. and Surgs., N. Y., and admission to his hospital operations is by sections of

his class in rotation, about ten being admitted at one time. He does not make any point as to the time spent in this operation. Each patient was assigned a cottage, isolated and containing two rooms, one for the patient and one for the nurse. Before the operation these rooms were thoroughly scoured with a disinfectant solution and the patients were briskly rubbed all over with a solution of the bichloride, 1 to 1,000. The operator and his assistants used the same solution upon the arms and hands. No other disinfectants were used during the operations. One of these patients had been taking 96 grs. of sulph. morphia per week.

Of the operations of laparotomy at the N. Y. Woman's Hospital during 1883, there were 80 per cent. of recoveries, some of the fatal cases being desperate at the time of admission.

A NEW EXPLANATION OF THE PROCESS OF INFLAMMATION.

BY PROF. J. PLAYFAIR M'MURRICH, GUELPH, ONT.

In the last number of the *Quarterly Journal of Microscopical Science* there is a translation of Dr. Elias Metschnikoff's paper "On the Mesodermic Phagocytes of certain Vertebrates," originally published in the "*Biologisches Centralblatt*." Metschnikoff has shown elsewhere that certain amœboid cells in the tissues of the invertebrates have the power of ingesting and absorbing food particles. On experimenting with vertebrates, he found that the connective tissue cells had the same power, and that, in a batrachian larva about to metamorphose, the absorption of the tail was brought about by these cells, which he terms "phagocytes." At the beginning of the metamorphosis these amœboid connective-tissue cells collect round the muscles of the tail, and gradually devour their fibres. The fragments of muscle retain their structure for some time after ingestion, so that that process can be readily seen to take place, but gradually lose their stration and break up into rounded strongly refracting globules.

In order to ascertain whether these "phagocytes" would absorb, and so eliminate from the system, injurious substances, Metschnikoff injected putrescent blood under the skin of a frog, so as to induce septicæmia. In a short time the white blood corpuscles (which are also included in the

term "phagocytes") were seen to contain both still and motile bacteria, and these organisms were especially abundant in the "hæmophagocytes" or white blood-corpuscles of the spleen. This fact, taken together with the probability that the spleen has no very important physiological function, since animals live without much apparent discomfort after its complete excision, seems to indicate a prophylactic function for the spleen, it being merely a protector against septic bodies such as bacteria, the removal of which from the body is its function.

To apply these facts to the process of inflammation. When inflammation was induced in the tail of a newt, the first phenomenon was the collection of connective-tissue "phagocytes" round the injured cells, followed by the passage of "hæmophagocytes" or white blood-corpuscles through the walls of neighbouring capillaries, both collecting apparently for the purpose of devouring and so removing the ruptured, dead and dying cells. In fact the essence of the whole inflammatory process may be said to be a conflict between the "phagocytes" and the septic material, whether the latter be a dead or dying cell, bacteria, or other foreign body. In the invertebrates, where connective-tissue cells are abundant, the vascular system does not participate in the process—only doing so among vertebrates, where the extra-vascular "phagocytes" are not sufficiently numerous to combat the injurious structures, a call for assistance being then given to the "hæmophagocytes." The first effect of irritation is on the connective-tissue "phagocytes," the changes produced in them subsequently influencing the capillary walls, and allowing the transit of the white corpuscles.

The theory has much to recommend it, being founded on logical, *à priori* grounds, and affording simple explanations for many obscure points in connection with inflammation. For instance it affords a simple explanation for the presence of the large numbers of connective-tissue and white blood corpuscles that have been observed in induced keratitis, and also it explains how in certain epidemic fevers—famine-fever for instance—numerous spirilla, etc., can exist in the blood of as yet unaffected individuals, without causing any symptoms of the epidemic. At the same time the theory is quite compatible with all definitely ascertained pathological facts, a circumstance which alone would give it considerable weight.

Correspondence.

COUNTER PRESCRIBING

To the Editor of the CANADA LANCET.

SIR,—The following is a free translation of an article in the *Union Médicale du Canada* for February, and I hope you may not find it unworthy of a corner in your journal.

"Almost every day complaints reach us in reference to the practices of certain druggists, who without hesitation lay aside the spatula and pill-machine, and donning the bonnet of the doctor, write prescriptions, give consultations, etc., and this in the face of the well-known provisions of the Medical Act—provisions which confer on licentiates of the College of Physicians and Surgeons alone the right to practise medicine and to collect fees for their services." "The attempts of Pharmacy to encroach upon the domain of Medicine is not a thing of recent occurrence, nor are we the first or the only ones who have complained of it." "Similar abuses have for many years existed in the United States and in Europe; and in those countries as well as here great difficulty is experienced in devising a proper remedy for their prevention." "In Montreal their increase is becoming more and more serious." "One particular druggist of this city has, to our personal knowledge, a patient abundantly able to pay, actually under his care as his medical adviser, from whom he annually receives a handsome sum, not only for medical but even for surgical services."

"One of our correspondents writes to us that in his quarter there is a druggist who does not scruple to substitute mixtures of his own invention, for those ordered in the prescriptions of the physician; and who sometimes does not give full weight of the medicines ordered (*when they are expensive, I suppose*), although never failing to make his customers pay the full price, just as if the full quantity had been dispensed."

"Another assures us that a druggist in his neighborhood practises medicine to so great an extent that he is obliged to employ a collector to look after his accounts; he draws teeth, opens abscesses, calls himself "Doctor" if you please; and Montreal does not perhaps contain a more *aristocratic gentleman*" (?)

A third correspondent informs us that the clerk

of an apothecary to whom he sends his prescriptions make a specialty of treating gonorrhœa, and that all the diseases of this nature in that locality pass through his hands, and that his business never seems to suffer any diminution. "In short, if the object of druggists be to create this sort of custom, and physicians send their patients there with prescriptions, they can very soon obtain the formulæ of prescriptions for different diseases, although they may not acquire a knowledge of the different methods of treating them."

"An individual presents himself at the counter of a drug store bearing a prescription signed with the name of some popular physician; this excites the curiosity of the druggist and he puts himself upon the alert. A few days after, the same individual presents himself again and requires the prescription renewed. Inquiry is made as to the effects of the remedy, and the response is that it has acted like a charm, and that this is the remedy that has done him the greatest amount of good.

"By means of a number of adroit questions the diagnosis of the physician is ascertained and then the prescription is carefully laid by to serve in its proper time and place.

"In this manner do our druggists educate themselves at our expense in the science and practice of medicine. According to this charming system of giving prescriptions which seems to satisfy us, and by means of which a prescription once given may be filled again as often as the patient or druggist has a mind to, we have nothing to do but sit down (Micawber-like) and wait for something else to turn up.

"Later on we shall return to this subject; for the present we content ourselves with calling the attention of those whose duty it is to interest themselves in such matters to these facts.

"We prosecute to the bitter end quacks and charlatans who do not injure us, it may be, one-tenth part as much as these practising druggists do; and with reference to this matter we think that if there is a law to regulate the practice of physic and surgery, the same law ought to apply to all classes alike."

Such practices as the above are so constant and so glaring in this locality that I cannot but feel in sympathy with my French confrère. It has been no uncommon thing for me to find some prescriptions of mine doing duty for a druggist in effecting

"magical" cures of coughs, gonorrhœa, rheumatism, or some other diseases the diagnoses of which are well known. A great many persons call every druggist "doctor" and calculate on doing their medical business with him, unless when they are so sick as to require the services of the physician at their own houses. Surely the law might be so enforced as to prevent this infringement on the rights of medical men, who pay dearly enough for their few privileges, by long years of study, examinations at college and before the Council, and by the weight of responsibility resting upon them, which in no way affects the standing or the income of the druggist that prescribes from behind the counter.

Yours, etc.,

THOS. R. DUPUIS.

Kingston, April 8, 1884.

Reports of Societies.

TORONTO MEDICAL SOCIETY.

Feb. 28th, 1884.

The President in the chair.

Dr. J. F. Ross read a paper upon the "Wintering of Invalids When, Where, and how to Go." After alluding to various resorts in Italy, France, &c., he said that Southern California possessed most of the requisites of an ideal health resort. Santa Barbara, on the coast of California, presented most of the conditions sought for by the unfortunates. It was situated on a southern slope towards the sea—protected on the north and east from the cold and dry winds from the adjacent desert, with a satisfactory temperature and rain chart, and all the benefits of a refined and wealthy society, and was within easy reach of other resorts, as the Ojai Valley, Los Angeles, S. Gabriel Valley, etc.

Dr. Aikins wished to know what class of cases would be benefited by a residence in high altitudes.

Dr. Nevitt said that Dr. Theo. Williams, had found those cases benefited most by high altitude whose disease was limited, the subjects of hæmorrhage, but not those subject to pyrexia. The chest measurements were generally increased and the area of dulness diminished, emphysema was usually developed, possibly by the greater respiratory exertion induced by the rarefied air.

Dr. Ross presented the stomach of Mrs. D., with the following history :—Mrs. D., æt. 66. Father died suddenly, æt. 77; mother died of paralysis, æt. 86. Two of her sisters are dead, one æt. 7 and one at birth; one sister and four brothers alive and well. Married young; husband died seven months afterwards; had one miscarriage at five months; three years ago had typhoid fever. Until three years ago was apparently well. Twelve months ago was ill with so-called remittent fever. In July, 1883, had a severe chill, pain in bowels, diarrhœa and tympanites, vomiting, anorexia, emaciation; skin became yellowish in colour. Never noticed any abdominal lump until lately. The tongue is red; appetite poor; takes beef tea and oysters without pain or discomfort; no vomiting for several days; some diarrhœa present, passing mucous shreds. Pulse 116; right foot swollen; left foot never swelled; respiration 36; no cough. The *post mortem* disclosed a cancerous enlargement of the lower and posterior portion of the stomach adherent in part to the pancreas; the right kidney was cystic.

Dr. Cameron exhibited a placenta illustrating fatty degeneration, and giving rise to premature delivery. It was very small and presented here and there numerous patches, yellow in colour, hard and resistant to touch, and varying in size from a pea to an almond in the shell. There had been no history of syphilis. Microscopical examination showed fatty degeneration with inflammatory infiltration and organization in parts.

Dr. Macdonald exhibited a placenta. Mrs. A., æt. 22, primipara, menstruated last in September; morning sickness was very troublesome. In December choreic symptoms set in, affecting the right upper extremity especially; but extending to the right leg and foot. The chorea was treated with liq. arsenicalis and oxalate of cerium in two-grain doses with some relief. About four weeks ago the foetal movements ceased to be felt, and afterwards the chorea disappeared. After a very rough drive pains set in, and there was a show, and one week after, delivery took place. Six weeks before delivery she lessened in size. The placenta was small, hardened, and degenerated in spots. There was very little tissue left to carry on the foetal nutrition.

Dr. Cameron considered the spots to be hæmorrhagic.

Dr. Carson thought the oxalate of cerium in the

doses given by Dr. Macdonald would possess little power. He had been in the habit of administering it in ten grain doses.

Dr. Graham related the history of W. L., æt. 45 : Hotel keeper for five years. Seven years ago he gave up hotel life and worked hard on his farm ; never had ague ; was very ill with measles at twenty years of age. Six years ago he had a severe illness. It began by his feeling sleepy, dull and weak. No appetite ; nausea ; took to his bed ; jaundice set in and remained during his illness, a period of three months. He had a burning sensation in the soles of his feet. Before the jaundice set in he was very pale. He gradually recovered strength and remained fairly well until last March. He then began to feel the same train of symptoms ; sleepiness, dulness, weakness, pallor ; no jaundice. He took to bed on April 25th, and remained there until the latter part of August. He was unable to retain food, much emaciated, constipation very troublesome ; at one time three weeks intervened without a passage from the bowels. His temperature was at or over 102° for weeks. During the latter part of his illness, he took a fancy for buttermilk which he retained on his stomach. Recovery slowly followed. He is now for the third time experiencing a recurrence of the same set of symptoms. A diagnosis of pernicious anæmia was suggested.

Dr. Carson related a case of hæmatemesis which he had treated without stypitics. Noticing that she had the pulse of high arterial tension, he had given her bromide of potassium to dilate the capillaries, and gray powder to act on the bowels. On a second occasion nitrite of amyl proved equally efficacious in relieving her.

MICHIGAN STATE BOARD OF HEALTH.

Reported for the LANCET.

The annual meeting of the State Board of Health was held in Lansing, April 8, 1884.

Dr. Vaughan read a paper prepared by Dr. C. P. Pengra, on the "Purification of water by freezing." As a result of a series of elaborate experiments conducted in the University laboratory, Dr. Pengra found, that, contrary to the general impression, freezing does not render water pure. Ordinarily he found less infusoria and bacteria in ice than in the water from which it was frozen, but the ice contained them in numbers sufficient

to preclude its use. In harvesting ice the greatest care should be taken to get it from a pure source.

It was decided to print the names and addresses of the health officers in Michigan, as soon as full returns were received. The number in the State is nearly 1,400. A new edition of the document on the prevention and restriction of scarlet fever was ordered to be printed. It was also decided to publish facts relative to several outbreaks of trichinosis in Michigan.

A resolution was adopted recommending Congress to pass a bill, providing for the prevention of the introduction of infectious diseases into the United States, and for procuring information relating to climatic and other conditions affecting the public.

The Board discussed the merits of several textbooks on physiology and hygiene, with special reference to the effects of alcohol on the human system, and approved for use in the schools Martin's "Human Body," briefer course, second edition, containing special chapters on alcohol and other narcotics ; and Dr. Eli F. Brown's "Alcohol : Its effects on body and mind."

OXFORD MEDICAL ASSOCIATION.

The regular meeting of the Oxford Medical Association was held in Woodstock on the 10th of April, 1884, Dr. A. McLay, President, in the chair ; Dr. A. B. Welford, secretary. Motions of condolence were passed and ordered to be sent to the widows of the late Drs. Coad and James.

The next regular meeting will be held in Ingersoll, on the second Thursday in July.

Selected Articles.

OPERATION IN INTESTINAL OBSTRUCTION.

Dr. Macleod in the *Glasgow Medical Journal* for March, says :—That of the six most important sources of obstruction—viz., intussusception, loops, bands, &c., twists, simple and malignant stricture, and internal strangulation by pouches, the three first are most frequently found in the right groin. Simple stricture is also, in a certain proportion of cases, situated there ; while malignant stricture is far more commonly seated in or below the left groin ; and internal strangulation has no special region where it can, in the majority of cases, be

looked for. The practical bearing of these observations will be apparent shortly. Now, let me very briefly review the different surgical operations which have been, and still to some extent are, practised for the relief of obstruction, and then we will be the better able to understand which of these procedures is best fitted to meet the different kinds of obstruction we have to deal with.

First, the abdomen may be opened in the middle line, or outside of the recti on either side, or a descending coil of bowel may be cut down on wherever it shows itself. The first is, on the whole, the operation which fulfils the indications in many circumstances, as it gives freest access to the whole cavity, and there is less risk of effusion between the muscular walls of the belly, and perhaps affords the best hopes of a rapid recovery. "Laparotomy," as it is now termed, is, however, a very serious and difficult operation in cases of intestinal obstruction. As is well known, it is in no way comparable to opening the belly to remove an ovarian or other growth, as not only are the patients on whom it falls to be performed usually much exhausted by the nature and continuance of their complaint, but the bowel is so much distended that its return within the cavity of the abdomen after the parts have been examined is always most difficult (in truth sometimes almost impossible), while the manipulation which is required to attain this end immensely increases the risks of the operation. The tension, too, which exists after the belly has been closed is so great that all hope of that rest and freedom from irritation, which is essential to the successful treating of such wounds is often destroyed. It is not a little remarkable how, before the belly is opened, in many cases the distension of the bowel may not appear great, and there may be no great prominence of the abdomen; but, so soon as the wall is divided, coil after coil of greatly enlarged and gas-distended gut come out, defying all means of repression or even protection, and causing the utmost dismay as to how best to deal with them. It is always most desirable not to puncture the distended bowel, as however small the instrument employed, there is always considerable fear of fæcal exudation, and ligatures often fail to bring the serous surfaces together so as to close the aperture. The walls of the bowel, too, are thin and weak from the distension to which they have been exposed, and so very serious damage may result. It not unfrequently happens that distinct rupture of the gut will take place where the puncture has been made. In replacing the extruded bowel, take what care we may, it is apt to be bruised and injured, and small extravasations of blood will now and again appear and escape into the cellular connection when pressure is withdrawn. The contact of the finger nail and tips must be carefully avoided, and sponges introduced between the hand and the bowel; but with all this and every care we

can use harm is too sure to follow. There can be little doubt but that it is the manipulation which does such serious harm in laparotomy, and it is probably this which renders the operation so disastrous. In ovariectomy and similar operations we do not, as a rule, require to touch the bowel, and occasionally it is never seen. Further, laparotomy is, in many cases, the only available operation in obstruction occurring in very young and weakly children, yet they are wholly unable to stand so terrible an ordeal.

The cases in which laparotomy is indicated are those in which we have to do with tumours which we desire to excise at the same time that we relieve the obstruction which they occasion; in cases of intussusception, if it is thought possible to disengage the invaginated bowel (that is—early in acute cases if it is to be done at all); in twists also, and in strangulation from internal hernia when we have to adjust the parts, and not merely to save life. It is probably the only operation by which a foreign body obstructing the bowel (not being fæces) can be extracted. In occasional instances in which the exact position of loops, bands, or adhesions can not be recognised, laparotomy may be our wisest proceeding, but of this more will be said. Cancerous tumours, if of small size, and situated in the small bowel, may thus be excised, and the bowel re-united, or a false anus established. If the tumour be in the large bowel, then after excision a false anus may be established in the loin or in the groin, as, it will be in the recollection of the president, I attempted in a patient I saw with him. This is better than attempting to unite that part of the bowel, but in the small gut suturing the divided bowel has most to be said in its favour. It is, of course, only in limited strictures that this operation (colectomy) can be attempted. By such an operation, we attempt not only to remove the obstruction but get quit of the disease. So laparotomy has this strong claim on our attention that it may enable us to carry out a curative, and not simply a palliative treatment.

When laparotomy has to be performed, it is best to make at first a small opening to enable us to search for the seat of obstruction without opening the whole cavity. This must be done with the greatest gentleness; afterwards, if it is found necessary, the orifice may be enlarged. It is the empty bowel which we seek for, and this lies in the pelvis. We trace it up to the place of obstruction. This plan is better and easier to accomplish than to pursue the opposite course, which is what is commonly done. As little bowel as possible should be exposed. A sponge wrung out of carbolic solution should be kept over the hand and wound. We should search first in the neighbourhood of the cæcum, and determine whether the mischief is in the greater or the lesser bowel. The cæcum is the best starting point in all these investigations, and

is a good landmark for our proceedings. If there is a portion of the bowel in a loop, or under a band, or in a pouch, we should draw on the lower or empty part, and this way experience has also shown to be the best way of disengaging an intussusception. If we have to deal with a small band we may break or cut it, but it is better to ligature a broad or large band at two places and divide it between the ligatures, as it is difficult and troublesome to secure any vessel which may bleed. If a foreign body is to be removed the portion of the bowel containing it should be drawn well out of the belly. After the substance has been extracted a false anus may be established by stitching the open gut to the superficial wound, or in favourable circumstances, the bowel may be united by suture. So much for laparotomy. It is, I repeat, an operation not to be undertaken with a light heart, or in any but the most desperate circumstances. There are other methods of operative relief which are much preferable, if they can be used. Of these, colotomy in the right or left loin would, of course, be chosen if we are so able to localise the obstruction as to be sure of opening the bowel above it.

In incurable obstruction seated in the rectum and sigmoid flexure—that is, low down, left lumbar colotomy (or Callisen's operation as it should be called), is the operation which beyond doubt would be employed; but it is sometimes far from easy to be sure that by that operation we can get quite beyond the obstruction even in cases in which we seem to have clear evidence to support that conclusion. The descending colon has been often opened after very careful examination, and the obstruction found to extend above the point opened. That the bowel can be safely and comparatively easily reached in either loin is well established and attempts have been recently made to revive Littre's operation (in which the sigmoid flexure is opened in front through the peritonæum, that is, in the left groin); yet all the difficulties connected with getting beyond the disease are in that operation much enhanced by the near neighbourhood of the disease even when it is confined to the rectum. The necessity of opening the peritoneum in operating will make surgeons slow to substitute an operation which was in former years condemned for its unfavorable results, for one which possesses so many stronger claims to success. If the obstruction lies in the descending colon, left lumbar colotomy (Amussat's operation) is that which should be preferred. No one has yet proposed to re-introduce Fine's operation, in which the transverse colon (which is surrounded by peritoneum) is opened; but in these days of obtrusive and restless innovation there is no saying what may yet arise. It is certain that in an immense proportion of cases of intestinal obstruction, the obstruction lies below the right loin. Bryant gives the proportion 15 to 1.

In the many cases in which the obstruction lies about the caput cæcum and the ilio-cæcal valve, Nélaton's operation (which is an extension and improvement of Pillore's) is beyond doubt the best surgical proceeding. Pillore opened the cæcum, but Nélaton demonstrated how by a very small incision in the right groin that region could be perfectly examined, and how with little risk life could be saved in irremediable cases by opening whatever coil of the bowel (necessarily the distended part, and so above the obstruction) protruded at the wound. The success of this operation has been great, and in the cases where I have myself had recourse to it, it has been most satisfactory in saving life. If the obstruction is such that it cannot be removed, or if the steps necessary for its removal (from the condition of the patient, involves too much risk, this is a most invaluable operation. No blood-vessel need be wounded. The bowel is not much handled or exposed, and an outlet is certainly secured for the imprisoned fæces. It is quite true that in most cases this is only palliative—that is, it does not remove the cause of obstruction in all cases, *but it saves life*. I hold it places the artificial anus at the most satisfactory place—a much better place than in the loin, as it is under the control of the patient, it can be dressed by himself without aid, and an apparatus can be best applied to restrain discharges. Finally, I hold that in the considerable residuum of cases in which we have done our best to determine the seat of obstruction, and have failed, that this right inguinal enterotomy is the right operation to perform.

In conclusion, I would say that, as a rule, if an operation for intestinal obstruction is to be performed, the sooner the better. In acute cases it is a question of hours, and in chronic cases delay beyond a week is inexcusable. Sometimes as in a recent case which I saw with Dr. Hugh Miller, our hand is held by the knowledge that similar attacks in the same patient have, after as long intervals, without interference passed off. But, as a rule, if internal remedies intelligently and perseveringly administered have failed to bring relief, then no good but only evil can come of delay. The using of purgatives should be by the rectum alone; and nourishment, too, as is well known, can be largely administered by the bowel, and it is well that full advantage should be taken of this knowledge. Exhaustion, peritonitis, and perforation are imminent, and the mere hopelessness of the patient will so oppose success that the operation can only lead to disaster. The length of time the obstruction has existed is not so good a criterion in determining whether we should operate, as the violence of the symptoms and, above all, the persistence of the vomiting, which does so much to exhaust the patient. Vomiting, pain, distension, are perhaps the most threatening conditions, and if they continue, are the strongest arguments for operation. If the

obstruction is from some mechanical cause, medicine can be of little aid, and the knife alone be of real service. If the surface is already cold and bedewed with sweat, the face pinched, the pulse weak and intermittent, the belly tender, and the courage gone, we should not interfere. The case is hopeless, and we are too late. Twists, internal hernia, and intussusception in very young children are almost always fatal, do what we like. Bands and chronic strictures are more encouraging, so far as operation goes.

In the preceding remarks I have carefully avoided reference to statistics, though these are abundant; but I have tried to embody the results of their teaching. I have not spoken of the use of the long tube, or of enemata, important and invaluable as these means of treatment in some cases are, because I desire to confine your attention as much as possible to the one point, the "choice of operation in intestinal obstruction." But I may say of the use of enemata in these cases the patient should be laid on the right side with the knees drawn up, and the fluid injected through the tube as it is passed, so as to facilitate its entrance. I would also desire to express in the most emphatic manner my conviction that, in cases of intestinal obstruction, purgatives kill many persons—if not by intensifying and aggravating their condition before the operation is performed, certainly afterwards by the violent action of the bowel to which they give rise after it is set free. The well-known rule of administering no solid food and only opium, and as little liquid as possible by the mouth should be strictly adhered to.

True it is that not a few cases of intestinal obstruction which seem altogether hopeless recover by the unaided powers of nature, and in some of these instances we cannot tell what was the cause which gave rise to the stoppage even after it has passed away. But, alas! these rare cases of recovery are too often allowed to warp our judgment and cause us to stand aside and abstain from interfering when an operation alone can be of any use. The great mortality which has attended operations for obstruction has had a pernicious influence upon surgical practice. We hesitate in the face of such terrible statistics of failure as past practice has recorded. But it may be that it is chiefly in this delay that the danger lies, and that bolder action might be the means of averting complications in these most unfortunate and anxious cases.

FREQUENT AND PAINFUL URINATION.

The following clinic is by Prof J. C. Skene, of Brooklyn (*Med. News.*):

Gentlemen:—To-day I desire to call your attention to frequent and painful urination arising from certain disturbances and anatomical lesions of the sexual organs.

Case 1.—Our first patient is thirty years of age, and has now been married eight months. Her health has always been fairly good until two months ago, when she began to suffer from frequent and painful urination. These annoying symptoms have continued ever since, and have also increased in severity. She states that in the morning and during the forenoon she is comparatively comfortable, and can retain her urine a reasonable length of time; but towards the afternoon the desire to urinate is frequent and urgent, and she has much pain in evacuating the bladder. These symptoms continue until night, and during the early part of the night she is compelled to rise several times and relieve her bladder; but after she has once fallen asleep she remains quiet until awaking in the morning at her usual time for rising.

Now the fact that she is able while asleep, to retain her urine until the bladder is distended to an average capacity, is an indication that the trouble does not involve the entire bladder, but that it is limited to the urethra, and, perhaps, the neck of the bladder. If she has a general cystitis the probabilities are that she would not be able to hold even an average quantity of water in the bladder at any time. We cannot, however, be sure as to the extent to which the bladder is involved without an examination of the urine, but it is fair to suppose, judging from her symptoms, that the trouble is limited to the urethra, and probably the neck of the bladder to a slight extent. It is a curious fact in her history that during the forenoon she is comparatively comfortable, but that her symptoms become aggravated in the afternoon, and continue during the early part of the night. This may be due to one of two causes.

First.—It may be due to the fact that the irritation subsides after lying in bed for a time, and does not return until she has been about for several hours during the early part of the day. The fact of her being upon her feet and maintaining the erect position, naturally brings more pressure to bear upon the neck of the bladder, and would thus aggravate an already existing irritation, and give rise to frequent urination, which continues until she again seeks relief by resuming a recumbent position in bed for a time. This certainly is one of the causes for this frequent urination in the later part of the day.

Secondly.—There is a cause which gives rise to the same peculiarity of clinical history, and that is *malarial poisoning*. A patient suffering from malaria quite frequently has irritability of the bladder indicated by frequent and painful urination, these symptoms being always most marked in the afternoon and evening. In this case, however, there is no indication of malarial trouble; so that the peculiarity of her history is no doubt due to the erect position maintained during the early part of the day.

Regarding the primary cause of her trouble, that

is not quite so clear ; there is no history of gonorrhœal inflammation which could have affected the urethra or bladder, as it sometimes does ; neither has she any uterine or pelvic disease which would directly or indirectly affect her bladder. It is barely possible that it arises from the change in her social relations ; having married late in life—some eight months ago—it is just possible that her family relations may have produced an irritation of the urethra and base of the bladder which, when once established, is very liable to persist if not relieved by treatment. Having an opportunity of examining this patient's urethra and the neck of the bladder, the probability is that we shall find a hyperæmic condition and perhaps some tendency to ulceration of these parts, but of that we cannot speak positively, as the examination has not yet been made, nor shall we trouble her with such examination until we see if we can relieve her by treatment.

In the treatment of this case we will render the urine as bland and non-irritating as possible, by permitting her to drink freely of the alkaline mineral waters—Vichy for instance—and in case she cannot procure that, we will order the acetate of potash. At the same time I will give her a favorite prescription in these cases : *R. Fl. ex. buchu, ʒ ij ; tinct. conii, ʒ j. Sig. ʒ j half an hour before meals.*

If this fail to give her relief, we will then employ injections of sulphate of zinc, half a grain to the ounce of water, with the addition of a drachm of the fluid extract of hydrastis canadensis. In using this local application, we will employ a syringe with rather a large nozzle, which is to be introduced just within the meatus, then slowly and carefully inject the mixture so as to force it along the urethra into the bladder ; being careful to have the bladder emptied previously. By adopting this plan we are sure of bringing the remedy in contact with the entire mucous membrane of the urethra. We will also request her to abstain from coition, as that may be the cause of her trouble.

Case 2—I have here a very interesting case brought to me by Dr. Stewart. This lady is forty-five years of age, unmarried. She gives us the following history : Up to six weeks ago she menstruated regularly every four weeks ; since four weeks ago she has menstruated three times, she is therefore suffering from menorrhagia. She has great pain in the back and suprapubic region, with frequent and painful urination ; altogether, suffering extremely, she says. I am now making but very little pressure upon the abdomen, and yet she complains very much. Upon examination I find an extremely interesting pathological condition here. Now bear in mind the prominent symptoms ; there are intense backache and pain in the suprapubic region with an abnormal condition of the menstruation and a frequent desire to urinate. Dr. Stewart, in carefully examining the condition of the

sexual organs discovered conditions which did not altogether coincide with her history as given by herself. He found the uterus large and well developed, with an os externum which looked as if it had seen service ; the same also of the perineum. Upon being questioned very closely, or, as they say in law practice, "cross-examined," she admitted that she had had a child five years ago, and had been also operated on for amenorrhœa.

This gives us a clue to the cause of the present condition of things which we have here. We find the uterus is large and the fundus is pointing towards the upper part of the symphysis pubis, the os looking towards the hollow of the sacrum, the body of the uterus is therefore pressing upon the bladder and crowding it downward—a condition which is sufficient to account for this frequent urination. The uterus is anteverted, and the symptom is the functional disturbance of the bladder, due, no doubt to the displacement. I here show you a specimen of her urine. We often have symptoms of cystitis being established. In this case we have vesical tenesmus because of the pressure of the fundus uteri. A normal bladder will tolerate pressure for a time, but after a while it will incite this frequent urination ; it is therefore a question whether or not we have cystitis here. You will observe in this urine that there is an abundant deposit of the phosphates ; if this clear up upon the application of heat, and we find no products of inflammation under the microscope, we will simply say that this is a mechanical derangement of function.

There is, however, another unfortunate condition here, and that is, that while the uterus is anteverted, it remains there in spite of all our efforts to restore it. It is anteverted and fixed in this position because of a former peritonitis. If she has been subjected to an operation for the relief of amenorrhœa, she has been in the way of having pelvic cellulitis or peritonitis, or both, and the evidence is that she has had one or both.

We have here, then, an incurable anteversion ; all that we can do is to relieve the symptoms ; we cannot remove the cause of her pain, backache, and vesical tenesmus ; we can only modify these while hoping that she will live long enough to pass the menopause and be relieved by the final involution of the uterus. The plan of treatment will be to try and relieve her general condition. This urine shows her nervous system to be below par ; when we have this brick-dust deposit, it is said to be a symptom that the waste of the tissues is in excess of the assimilation for their support. It is said of clergymen that the deposit of phosphates in the urine is greater upon Monday than any other day in the week, by reason of the using up of the nerve force on the preceding Sunday. It is possible that we may improve this woman's general health so that her system will be able to tolerate

her local difficulty, and thus bear her suffering much better.

It is impossible to use a pessary in this case as the uterus is fixed ; part of her vesical irritation may be due to the fact that there are adhesions of the bladder, so that now it is impossible for that organ fully to distend. The peritonitis has probably extended in front of the broad ligaments forming adhesions, and thus holds the bladder in a splint so that it cannot extend ; this may be another cause of her frequent urination. So that we have here two factors ; the displaced uterus, and the thickening of the peritoneum upon the walls of the bladder which prevent its distension. We can do little but apply the douche and paint the vaginal roof with iodine ; we can also introduce a balladonna suppository if advisable. This, however, as I have told you, can only be palliative.

This case is an exceedingly important one, as those who are most prone to this condition are those who abuse the generative functions.

There is one thing more here which, however, hardly comes under my Chair. We find above the umbilicus a marked pulsation which may be an aneurism of the aorta, and which might possibly account for some of the abdominal pains.

Case 3—Our next case is also one of incontinence of the urine ; the cause, however, of this condition in this patient is entirely different from that of the preceding ones, and therefore must not be arranged under the same head. The patient, however, comes to us suffering from this incontinence, and I now present her to you as illustrating another cause of this difficulty. This little girl is twelve years of age. When she was three years old she had an attack of scarlet fever, and has never been well since ; she has not accomplished much in the way of growth or development ; she looks somewhat anæmic. During the night she has to get up six or seven times to pass her water, and, unless exceedingly tired, the desire always awakens her. During the day the passing of water is equally, or more frequent ; for this reason she has been unable to attend school. This is very interesting, as it illustrates a class of cases which you will meet quite frequently. When urinating there is always pain, and she informs me that, if she attempts to restrain herself, it increases the pain ; but immediately upon evacuating the bladder there is complete relief for a time. For the last nine years this has been going on. It is, however, a rare thing as a rule in this difficulty for the patient to awaken at night, the urine being generally passed in bed. This is a most miserable condition for a child to be in, been obliged to get up to urinate many times every night, or else to sleep in a bed saturated with urine.

Acute cystitis often follows the eruptive fevers, and sometimes in these cases it becomes chronic, as in this case, so that we should always be on our guard in the eruptive fevers and see to it if there is

any cystitis following, otherwise the result will be the same as in this case. Now, whether the child has general cystitis or an inflammation of the neck of the bladder with urethritis remains to be seen. The way to make the diagnosis is repeatedly to examine the urine, selecting the last drachm or two which passed, and if it contains pus and epithelium we may be tolerably sure that there is general cystitis. The order of the development of the pathological conditions in this case is as follows ; first, scarlet fever, which gave rise to acute cystitis, or urethritis, which in place of ending in recovery, ran into the chronic or continuing variety.

CATARRHAL JAUNDICE AND CHRONIC BRIGHT'S DISEASE.

CLINIC BY PROF. BARTHOLOW.

The case of jaundice before you is one which you have seen before. An attack of jaundice rather persistent, as this one has been, and occurring in a man at this period of life, is by no means a small matter, and would be looked on with solicitude by any practical physician.

Let me state what has been the result of treatment. The patient tells us that he has gained two pounds during the past two weeks. The jaundice has disappeared, and the symptoms depending on it have passed away. The stools are natural in color and the deep coloration of the urine no longer exists. He, however, has some itching of the skin. This is due to senile changes in the skin, especially in the terminal portion of the nerves, the end organs.

In this case phosphate of sodium has been used persistently, and after a time the chloride of gold and sodium were added. I have repeatedly called your attention to the remarkable value of these two remedies in this affection, namely catarrhal jaundice.

There is another point I may mention before dismissing the patient. No case of catarrhal jaundice is without importance. It has been shown by experiment, and by clinical observations, that if there is any obstacle to the outflow of the bile for any length of time, the liver undergoes structural change. Hyperplasia of the connective tissue first occurs, then follows contraction. This is not the spirit or the drinker's liver, but it is allied to that condition, although the change is not so marked. Hence, I conclude that no case of catarrhal jaundice is without importance, for the longer it continues, the greater is the danger of hyperplasia of the connective tissue and permanent structural changes.

I have brought the case before you to show what can be done by appropriate remedies, and the persistent and faithful use of such remedies.

This young man had an attack of gonorrhœa

two years ago, which was followed by cystitis. This finally led to a complication on the part of the kidneys, and he probably had what is commonly termed surgical kidney. The occurrence of the renal complication was announced by the presence of albumen in the urine. He now has albuminuria, and the legs and feet are somewhat oedematous. The hands also look puffy, although there is no distinct oedema. The general appearance of the patient is good. One who has had albuminuria for a year usually presents an appearance of anæmia, which does not exist in this case. On examining the urine, we find a large percentage (10 per cent.) of albumen, and at times the proportion is probably greater.

The symptoms are not limited to those which I have mentioned. Examination of the eye reveals white spots in the retina, the evidence of albuminuric retinitis. There are also cardiac changes. The action of the heart is strongly heaving. The changes in the peripheral arteries which belong to this malady are also found. There is hypertrophy of the heart, which causes the strong, heaving impulse, and there is high tension in the arteries, due to the hypertrophic condition of the muscular layer of the arteries.

You have often seen these cases, and I shall not go further into the morbid changes, but I want to say something in reference to the treatment. These cases are readily diagnosticated, but the difficulty is in the treatment. We now have at our command some remedies which exert a remarkable effect upon this malady. The first of these is nitro-glycerine. Its introduction has given quite a different complexion to the treatment of these cases. This remedy is employed in the form of the centesimal solution; one minim of nitro-glycerine dissolved in one hundred minims of alcohol. One minim of this one per cent. solution is the beginning dose. This may appear to you an extremely minute dose, but try a few minims of this preparation and see if your respect for the activity of this drug is not increased. In some persons the action of the heart is accelerated and the face flushed by a single minim, while others may take from five to fifty minims. I had, a short time ago, a patient who could take eighty minims of this solution, not only without injury, but with decided benefit. This was a case of spasmodic difficulty of breathing. In albuminuria, I have found that the dose readily borne by an adult is from one to five drops, the average probably being three drops. You should begin with the smallest dose, and gradually increase until the characteristic symptoms are produced. It is necessary to produce these characteristic physiological effects in order to obtain the best results. I cannot too strongly insist on that proposition. Unless these effects are produced, curative results cannot be expected. It is fortunate that these effects can be obtained without any injury to the

patient, provided the remedy is used in anything like the proper dose. It is perfectly safe within these limits.

Why do we give nitro-glycerine? We should always have a reason for the faith that is in us. For the effect which nitro-glycerine has on the circulation and its secondary effect upon the structure of the kidney. Nitro-glycerine produces marked dilatation of the peripheral vessels. This at once takes away the blood from the important large vessels and central organs, and distributes it to the periphery. Of course, when the arteries are suddenly dilated, the work to be done by the heart is reduced, and it can send the blood on the round of the circulation with less force. Nitro-glycerine in this way relieves the heart and lowers the high tension which belongs to this malady. Secondarily, it opens the way to the relief of a condition that had hitherto not been relieved by any measure which he had under our command.

I have, however, another reason for my faith; that is, practical experience. It has been demonstrated that this remedy has a remarkable influence, and that the amount of albumen progressively diminishes under its use. The extent of improvement depends upon the amount of damage which the kidneys have suffered. We cannot restore lost parts. We cannot put new structure into the kidney, any more than we can restore a finger that has been amputated. If we wish to accomplish good, we must begin early. There is no time to be lost in this case. I shall begin with the administration of minim doses of the centesimal solution of nitro-glycerine, four times a day, and gradually increase the dose until the patient feels the characteristic flushing of the face and other symptoms produced by this remedy.

Have we any other remedy? The drug to which I have just now alluded as potent in preventing hypertrophy of the connective tissue of the liver, is equally potent in preventing hypertrophy of the connective tissue of the kidney. The result to be secured is exactly the same. In addition to this reason for the use of chloride of gold and sodium, I can again quote experience. I have seen remarkably good results from the exhibition of this remedy in these cases. The dose is one-twentieth of a grain three times a day.

In addition to this, the bowels should be kept in good condition by the use of a weak saline water, the function of the skin is to be kept active by the use of warm clothing, and the patient should carefully guard against changes of temperature.

There is another remedy which is also a food, that is skim-milk. The patient should live largely upon this, which acts as a diuretic as well as a food. As a rule, he should avoid solid food, living almost exclusively on a liquid diet. As he improves, the amount of solid food may be increased. These hygienic measures are of the greatest importance,

for without them it is hopeless to expect a favorable result from any method of treatment. — *Col. and Clin. Record.*

EXCISION OF THE ANKLE.

Dr. F. Lange, of New York, presented before the New York Surgical Society, Feb. 26th, 1884, (*N. Y. Med. Jour.*) six patients in whom he had excised the ankle joint more or less extensively within the last two years. In five of these cases the operation was done for scrofulous disease. The patients were at the time of the operation from one and a half to nine years old. In one case a gunshot injury gave the indication; the patient was eighteen years old. He said, I shall omit to ventilate the question, how far there is the indication to excise the ankle joint for scrofulous disease. Certainly a great difference of opinion exists regarding this point. A good many surgeons, especially in England and America, are in favor of expectative treatment. During six years of living in New York, I have not seen a single excision of the ankle joint except one, which, strictly taken, was no excision; nor have I heard of one; and I am perfectly aware that in children a great deal can be achieved by mere expectative treatment. On the other hand, I hope to prove by my cases that very good results can be reached by excision, that the disease in some cases is undoubtedly shortened by years, and in one or the other may have saved the limb. The prejudice prevailing against excision is mostly based, I believe, on deficient knowledge of good after-treatment, and in some degree on inattention to the technique. To these two points I shall principally direct your attention.

Regarding the operative procedure, I do not offer anything new. The genius of Langenbeck has presented a method which, in spite of all new, more or less sensational modifications, is by far the best in every respect. It causes the least injury, gives the best guarantee for new formation of bone, if that can altogether be expected, and allows of sufficient insight over the field of operation. To make the operation still more strictly subperiosteal, I remove the periosteum, in all those places where ligaments or tendons are attached, by means of a chisel. In small children, where the epiphysis is mostly cartilaginous, free use can be made of the knife. The bones are removed by means of a sharp chisel also; eventually a cross-cut is made through the periosteum of the tibia below the line of intended separation, to obviate tension and to allow of free access for the chisel. In this way also superfluous denudation of the bone is avoided. The chisel must be sharp and thin, and form, by means of numerous small cuts, a smooth perpendicular surface on the cross-cut of the bone remaining—to be sure, at the expense of the specimen.

I always unite the periosteum-cylinders by a few cat-gut sutures. In all cases the fibula has been excised also. In the traumatic case the astragalus was left untouched, in one case only its articular surface has been removed, in four it has been removed entirely. In one case complete *évidement* of the os calcis was added. I need not say that antiseptic principles, with the permanent antiseptic dressing, decide the wound treatment. The limb is suspended by a long, anterior plaster-of-Paris splint, after the manner of Beely, into which iron rings are fastened. It reaches as far as the middle of the thigh, and keeps the knee in a somewhat flexed position.

Great care must be taken during the wound dressing to keep the foot in such a way that it is not too much pulled forward. The assistant who holds the foot is very apt to commit this blunder. In this way the axis of the bones of the leg falls behind the intended point of the new joint, and you will see in some of my cases that I have not been entirely able to overcome this deficiency. In cases where the whole astragalus has been removed that might not be any disadvantage, because the bones of the leg are then supported by a part of the os calcis which is lying more toward the middle line of the foot and transfers more of the weight of the body upon the heel. In this way, I presume, the formation of pes valgus later on is avoided with more certainty. Where, however, the astragalus is left, the correct relation of the axis of the leg must be strictly observed. It is good to support the thigh and calf during the wound dressing, and to advise the person who holds the foot to fix it more by tender manipulation and slight extension than to contribute anything to raising the limb.

After the wounds are healed, which can be achieved usually under a few dressings, within, let us say, from six to eight weeks (in some of our cases it was four weeks; in one, the most extensive, the wound is not entirely healed after almost five months), the patient gets a light dressing of paste-board and starch bandages, or silicate, with quite thin wooden splints interposed. This dressing goes upward to the middle third of the thigh, and reaches down to the toes, keeping the knee slightly bent. It is split anteriorly, and can be removed and reapplied by means of straps and buckles. * I should advise cutting out the region of the heel to such an extent that, for reasons mentioned above, the foot can be slightly pushed backward within the dressing. I extend this dressing above the knee in order to avoid rotation of the leg within the dressing.

Now comes a very important stage of the after-treatment, during which, by means of active and passive movements, electricity, and bathing, the muscular action is stimulated. For this purpose the dressing is often removed and exercise done

while the patient is in the lying posture, the limb being raised as much as possible. By and by the child is made to push away a hand, which offers a slight resistance. In this way the young parts are accustomed to pressure, and after some weeks they will be so far advanced that, with the dressing, which must fit very accurately, and allow only of a slight weight being thrown upon the foot, they commence to walk. The parents must be inspired with the importance of devoting all their attention to these exercises. After several more weeks (in four of my cases in about two months after the operation) the patient gets a good-fitting double splint, which is inserted in a strong laced shoe, allows of a movement of about twenty degrees in the region of the ankle joint, and reaches as high as the head of the tibia. Here it ends in two side-pieces, which form the upper part of a pretty strong leather cylinder. The latter must be adapted very well to the upper half of the leg as far down as the lower edge of the calf. If the patient has sufficient means, it is good to furnish every lateral splint with a mechanism by which the distance between the condyles and the sole can be increased. This can be used very well to correct abnormal pronation or supination. To improve an abnormal dislocation of the foot forward, pass an elastic ribbon across the lateral steel splints, which presses slightly against the posterior surface of the lower end of the tibia and fibula. The apparatuses will probably have to be worn for years. So far I have not deemed it advisable to remove the splint in any one of the children, though in one the operation was done almost two years ago. Four of these children run about all day, and one would hardly suppose that they had undergone such extensive operations.

RUPTURE OF THE BLADDER—RECOVERY.

Dr. Weir reports the following case in the *N. Y. Med. Record*, March 29th:—An Italian laborer, aged twenty-eight years, was admitted to the New York Hospital, November 20, 1883, having been injured a short time previously by a bank of earth falling on him while engaged in making an excavation for a gas-pipe in the street near by. The accident occurred about ten o'clock in the morning, and on enquiry it was ascertained that he had had no alcoholic drink that day, and had urinated not long before the receipt of his injury. The mass of earth that fell upon him struck most heavily on his pelvis and left hip. When he was admitted no shock existed and his general condition was excellent. There was noticed a slight ecchymosis of the scrotum and a spot of blood at the meatus urinarius. This fact led the house surgeon to pass a rubber catheter, which gave exit to a moderate amount of bloody urine which became clearer as it flowed. Palpation over the

supra-pubic region gave rise to a little pain; considerable tenderness was felt over the left hip, but no evidences of pelvic fracture were obtained.

The patient passing urine with some difficulty and at times bloody, the catheter was passed during the next twenty-four hours three times. General condition good, though increased tenderness was then experienced in the hypogastrium.

November 22d.—The injury had been considered until to-day as a slight urethral laceration, but the marked increase in the supra-pubic dulness, which now extended four inches above the pubis and across into each groin, with tenderness, led to a closer examination of the patient. The catheter was passed readily into the bladder and only occasionally gave exit to blood-stained urine. The urine itself was passed at times voluntarily, and was not apparently diminished in amount. The temperature was but 99°. Abdomen not distended though its walls above the dulness somewhat rigid. Condition still good. No signs of fracture elicited, but the finger in the rectum detected a softer spot on the left side of the prostate which was decidedly painful. The ecchymosis of the scrotum and perineum was now very pronounced.

November 24th.—The temperature had risen to above 100°, pulse 104°, and patient began to be restless and disposed to vomit. Tympanites increasing, with abdominal tenderness not only above line of dulness but below it. A large hypodermic needle inserted in the hypogastrium drew out some bloody fluid with an acid reaction and urinous odor. Nothing distinctive could be felt in the rectum. The patient was etherized, and an incision, under sublimate irrigation, 1 to 1,000, was made three and one-half inches long in median line, midway between symphysis and umbilicus, until the subperitoneal cellular plane was reached, where a large cavity, containing at least a pint of bloody, undecomposed urine, was found. The finger could be carried its full length behind the symphysis, but nothing was detected. To effect a more complete diagnosis, as well as to allow of the carrying, if possible, of a drainage-tube from the hypogastric opening down and out of the perineum, the patient was placed in the lithotomy position, and on a staff introduced into the bladder a median incision was made, opening the urethra just anterior to the prostate. The finger passed in here toward the bladder revealed a rent running along the left side of the roof of the prostate which was lost in the wall of the bladder itself. Its upper limit was not defined, purposely, to avoid extra damage to the parts so favorable as they already were. Through the supra-pubic incision a large silver catheter was carried, and, aided by the finger in the perineal wound, was caused to pass through the laceration of the bladder and emerge from the lower wound. To the eye of this catheter a thread was attached, and a large rubber drainage-tube

pulled through as the silver instrument was withdrawn. Each end of the tube was secured by a suture to the skin, and a second drainage tube was then passed into the bladder, and its external end also fastened in the perineum. The cavity of the extravasation and the bladder were carefully washed out with a warm sublimate solution of 1 to 2,000, and iodoform gauze placed over each wound, though so lightly that urine could readily flow through the dressing.

The progress of the case was in every way most satisfactory, as is shown in the following notes from the case-book of the hospital. Dressing reapplied at 7 p.m.; temperature, 100°; all urine escapes through tube.

November 25th.—Condition improved, little pain; temperature, 101° all day; dressings changed and tubes irrigated.

November 28th.—Patient doing well; temperature still elevated (100°). Tube in bladder removed on 27th; urine passed by the other tube, which has been shortened daily from the perineal end.

December 2d.—Temperature normal; urine is still forced through tube into abdominal incision; tube removed from this opening and placed in perineum.

December 5th.—Patient himself removed tube from perineum last night, and much pain followed, replaced this morning; it drains thoroughly; cavity washed out daily with sublimate solution.

December 9th.—Patient removed tube last night and it could not be replaced; urine voided by the penis with little pain.

December 24th.—Wound in perineum closed; wound in abdomen only a linear ulcer. Allowed to go out of the hospital to-day.

OBSTRUCTION OF THE ABDOMINAL LYMPHATIC GLANDS.

BY ROBERTS BARTHOLOW M.D., ETC., PHILADELPHIA.

The first case which I bring before you is one presenting many points of interest, but its diagnosis is by no means clear. There are certain objective symptoms, however, which are very patent. For over two years this young man has had the swelling of the inferior extremities which you see. This swelling does not pit on pressure, in the ordinary way. There is some depression on pressure, but it is not ordinary pitting. The skin and subcutaneous areolar tissue are thick and firm, and the swelling does not present the ordinary characteristics of simple œdema. There is, besides the swelling, a change in the subcutaneous connective tissue—a change allied to that which takes place in the peculiar affection called myxœdema. This disease, which has lately been described, is characterized by a mucoid degeneration of the subcuta-

neous connective tissue, and is connected with atrophy of the thyroid gland. This change is, as a rule, especially well marked about the face. This malady was first described by Sir William Gull, of London, and was entitled by him a cretinoid state. It occurs most frequently in women, but it is also met with in men.

I do not mean to affirm that this is a case of myxœdema, but I desire to impress upon you the fact that there is a change in the connective tissue which allies this case with myxœdema. No renal disease, no cardiac affection, no œdema of the cellular tissue could give rise to this condition.

It is a curious fact that myxœdema has been found to be associated with atrophy of the thyroid gland. The effect of extirpation of this gland has lately been studied, and it has been found that subsequent to the surgical extirpation of the thyroid gland, a change analogous to that which we see in this patient takes place.

There is another peculiarity which at once attracted my attention when examining this patient, *i.e.*, that on the slightest pressure the skin assumes a distinctly red hue. When I draw my finger across the abdomen a well marked red line is left, and the slightest excitement, emotion or exertion causes him to get very red. In other words, the capillaries of the skin are in a condition of dilatation. There is a paralytic state of the vaso-motor system with which the circulation in the capillaries is concerned.

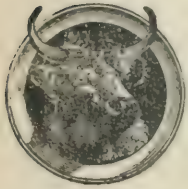
It is a perfectly well known fact that when there is obstructive disease of the capillary lymphatics, a change like this occurs in the connective tissue. This at once suggested that there might be some condition of obstruction of the lymphatics of the lower extremities.

What has caused obstruction in these lymphatics? The patient tells us that he has attacks of what he calls intermittent fever, during which the glands in the groin become enlarged and red, and painful lines extend down the thighs. This throws some light upon the affection. There are temporary attacks of obstruction of the lymphatics of the inferior extremities. This is very evident at certain periods. There is also a permanent obstruction, which has existed for two years; what has caused this?

The abdomen is full, more so than is usual. Even when the lungs are completely emptied, the abdomen remains full, so that I cannot, either by touch or percussion, demonstrate the existence of any enlarged body in the abdominal cavity; but taking the symptoms in connection with the history, I have no doubt that there is disease of the intra-abdominal lymphatics, causing obstruction in the lymph channels of the limb and swelling.

I have already stated that the circulation is peculiar. There is paresis of the vaso-motor system, which is shown by the state of the skin after exer-

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"Caviar.....25.81 %	"Fowl (Breast)16.56 %	"Oysters.....5.78
"Revalenta19.93	"Egg 13 48	"Cow's Milk.... 4.00
"Fresh Beef.....18.53	"White Bread 7.20	"Extractum Carnis (Liebig's Beef)3.20
Beef Peptonoids.....		70.75 %

Dr. Stutzer further touches upon the often exposed but still very prevalent error as to the nourishing power of Beef-tea ; and proves that *we would require to take a half-gallon of beef-tea, made with a pound of beef to each pint of water* to secure the amount of nourishment contained in one-quarter of a pound of steak.—*New York Medical Times.*

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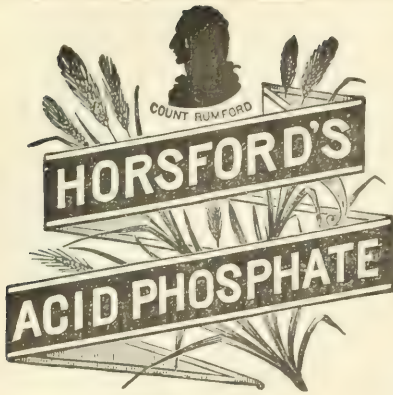
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tion, excitement or pressure. Has this any relation to the condition of the lower limbs? I think it has. What can be the origin of this condition of the capillaries? There is no cardiac affection, and the solution of the difficulty is probably found in intra-abdominal pressure on the sympathetic, so that it produces this obstruction of the lymphatic circulation below; it also causes the paresis of the vaso-motor system. I admit that this is not a very certain diagnosis. The problem is very obscure and the terms of the problem are somewhat uncertain, but taking it all in all, such is my explanation of the phenomena.

What is the treatment? Assuming that the diagnosis just announced is correct, what is the therapeutic diagnosis? The problem is, how shall we get rid of these enlarged lymphatic glands within the abdomen? What remedial measures can we employ to diminish their size, to change their character, to restore the lymphatic circulation of the limb and remove this enlargement? There are certain remedies which do undoubtedly affect the lymphatics; mercury is one. Iodine and the iodides are other remedies which have the same effect. Manganese and iron, under certain circumstances, also act on the lymphatics. We can at once dismiss the last two, for the appearance of the patient does not indicate the need of iron. This brings us to remedies such as mercury and the iodides, which have a selective action on the lymphatic system. I shall give this patient twenty grains of iodide of potassium three times a day, and also one-twentieth of a grain of bichloride of mercury, with one grain of extract of cinchona, three times a day, in the form of a pill. As you see, I do not give the iodide and mercury together. I direct a simple solution of the iodide to be made and the patient to take twenty grains in four ounces of water, three times a day, before meals, so as to secure its diffusion through the system before the mercury is administered. I think that it is always an error to combine these two remedies, for in such a combination you do not, as is commonly supposed, obtain the beneficial effect of both drugs. In the course of two weeks we should see some results from this treatment.—*Col. and Clin. Record.*

TREATMENT OF ACUTE ABSCESS.

BY STEPHEN SMITH, M.D., NEW YORK.

In many instances of the ordinary acute abscess, I have recently had excellent results in treating them for immediate cure. The following example illustrates the course pursued:

A man had an abscess on the external part of the thigh, resulting from a severe fall. There had been a high grade of inflammation, much suffering, and a temperature of 103°. At the time of the operation the temperature was 101. There was

fluctuation, but the pus was not very near the surface. The treatment was as follows: When the patient was fully under the influence of the anæsthetic, the parts were thoroughly washed with soap and water and a flesh brush, and then with a douche of corrosive sublimate solution 1 to 500. Then the abscess was opened with a knife, treated with a carbolic solution 1 to 30, the opening being of a size to admit the nozzle of a Davidson syringe. The depth of the abscess cavity was two inches. The pus was forced out by pressure, and when it ceased to flow the nozzle of the syringe, well disinfected, was introduced and the edges of the wound held firmly around it. The cavity was then distended to its fullest capacity, with corrosive sublimate solution 1 to 5000, the amount of water injected being one pint. Withdrawing the syringe tube, the solution was forced out, with strong and gentle pressure. This injection, and hyperdistension was repeated three times, when the water flowed away quite undischored. An incision was then made down to the cavity of the abscess, its full length, the incision being six inches long. With tenacula the edges of the wound were held apart, and the entire cavity exposed. During this part of the operation the irrigation with the corrosive sublimate solution, 1 to 2,000, was continued. The internal surface of the abscess was covered with large granulations and shreds of broken down connective tissue. The process of cleansing the wound was next begun, with disinfected hands and instruments. All the shreds of tissue were carefully dissected away, and the granulations were gently scraped off with the curette, until a perfectly clean surface was everywhere apparent. Several small vessels were ligated with carbolized ligatures, and the whole surface of the cavity thoroughly irrigated. The wound was closed with the interrupted suture, except at the lower extremity, where a small opening was left for drainage, over which was placed a disinfected sponge to absorb the discharge. The external wound and adjacent skin were sprinkled with iodoform; folds of gauze, between which iodoform was sprinkled, were applied around the limb from below the knee to the hip; over these layers, a dressing of borated cotton was wrapped about the leg and thigh; and over this was applied a light plaster of Paris dressing, which completed the operation. On the following day the temperature had fallen to normal, and did not rise again to 100, the pain entirely ceased; the appetite returned; sleep was sound and undisturbed. The patient stated that from his recovery from the anæsthetic he had felt entirely well. The dressing was removed on the eighth day. The wound was entirely closed, and though there was some thickening of the tissues involved in the injury, there was no tenderness. He could walk without pain or inconvenience, and there was a rapid subsidence of the swelling of the part.

It is safe to estimate that this man saved at least a month in time by the operation. What was saved in pain, impaired health, and possible dangerous sequelæ, cannot be estimated. I have operated for acute abscesses of the neck, back, groin, etc., in a similar manner, and have not failed of rapid and complete recovery without further symptoms.

This operation may be extended to furuncles and carbuncles when they have a local origin. The exciting cause is some small necrosed tissue. If this irritant is early and thoroughly removed, and the parts rendered aseptic, the disease will be arrested. Carbuncle of the face, the so-called malignant pustule, has long been treated, and generally the disease is arrested, by early incision, filling the wound with spirits of turpentine. The value of this treatment was supposed to lie in the local suppuration induced, but it is more probable that the turpentine acted as an antiseptic. If the surgeon would go a step further, and not only make a free incision through the inflamed tissues, but carefully scrape off, as far as possible, all diseased structures, and render aseptic the surfaces of the wound by the remedies now found so efficient, the disease could doubtless be arrested in its incipient stage.

We are evidently on the eve of the adoption of measures for the *prevention* of this formation of pus in a great number of cases where hitherto the practice has been to encourage suppuration as the proper method of cure. Indeed, there is little doubt that the time is at hand when the very presence of pus in the practice of surgery will be evidence of the inefficient use of remedial measures.—*The Æsculapian*.

THE TREATMENT OF PILES BY INJECTIONS.

Dr. Wm. H. Veatch, of Carthage, Ill., who has had considerable experience with this method of treating piles (*Peoria Med. Monthly*) gives the following answers to a number of questions addressed to him by correspondents desiring explicit instruction regarding the operation :

I confine myself to two principal modes of examination. 1st. The knee-breast position of the patient, placed on a table two by six feet, well cushioned. My stand is taken on the left side of the patient. Pressing the nates apart will reveal any external tumors which exist ; or the finger may be introduced through the sphincter ani to explore for internal tumors. 2nd. I place the patient on the table, on left side, the limbs flexed on the body, the right limb being drawn higher than the left, with the knee resting on the table ; then make the examination as before.

Piles originate from a common cause ; i. e., ob-

struction of the hemorrhoidal veins, therefore they are of the same nature and may be cured by the same treatment. The ordinary hypodermic syringe of Tiemann & Co. is the one I have always used.

The management of the needle is an easy matter when your patient is in proper position and the tumors properly exposed. Use due caution in filling the syringe ; see that no air is left in the barrel ; insinuate the needle gently into the tumor at any point from which you can most easily reach the sac, or center of the tumor. I have sometimes thought I have had better results from depositing the remedy at the base of the tumors, but in so doing I am aware that I risk depositing the fluid in the cellular tissue beyond the hemorrhoidal tumor, or in an unobstructed vessel beyond the limits of the tumor. In such an event I can easily see how we might realize Dr. Allen's fears of embolism. The safest plan, therefore, is to pierce the tumor at its apex or centre.

I have used all strengths, from equal parts of carbolic acid and water to that of only five per cent. of acid, and have had good results from all ; but as a rule I use a twenty five per cent solution. Patients will bear this strength as a rule without complaining. I have used tr. iodine, sol. subsulph. ferri, tr. ferri chlor., sol. plumbi acetat., sol. zinci sulph. and simple cold water ; anything that will coagulate the blood. Several of the above act more promptly in that way than carbolic acid, but my experience is in favor of the acid on account of the readiness with which absorption takes place after its use. A little alcohol thrown into the tumor after the coagulum has formed will assist absorption.

The following is the formula I employ : *R* Acidi carbolici ; glycerini, aa fl ʒ j. ; morphinæ sulph. gr. viij. ; aquæ dest., fl ʒ ij. *M. Sig.* Inject from five to ten drops into each tumor once in two weeks.

In nervous persons, who are easily hurt, and complain of very slight causes of pain, I inject but one at a time, but frequently I inject all at once if there are half a dozen.

External tumors are always much more painful under the operation, and are much longer in being absorbed. Occasionally tumors suppurate and discharge considerable quantities of pus, just as they frequently do without an operation of any kind ; but these pus sacs usually granulate and heal with but little difficulty.

I give great latitude in regard to the time necessary to a cure. They have run all the way from five days to five months. A great deal depends on the length of time the tumors have existed.

When the tumor is once cured the vein at that point is obliterated and cannot fill again ; but obliterating the vein at one point will not prevent a tumor from forming in any other part of the vein.

The length of time which patients suffer after

treatment depends in a great degree on the condition of the patient, and the strength of the solutions used. Ordinarily the first twelve hours puts an end to the pain, *i. e.*, the pain consequent upon the treatment.

The finger and the eye are all the instruments necessary for an examination of any case. A two-valve speculum, a tenaculum and scissors, a camel's hair pencil and a sponge are all the instruments you will require, besides your syringe, to treat any case of true hemorrhoids.

I can now call to mind only two cases who went to bed in consequence of the treatment. Almost all say that the pain of treatment is not to be compared to the pain they have suffered during the inflammatory stage of the recently filled tumors.

These are answers to the principal questions I have been able to cull from the mass of letters I have received, and I have to regret that my space will not allow me to enter more fully into the discussion of the various topics represented by my correspondence.

Now I will say to one and all, that the disease is to be treated as all other diseases must be, by the expenditure of a good proportion of common sense, and if one does not understand it he had better keep hands off. Always remember Prof. Andrews' admonition :

"This or any other plan is not exempt from danger when practised by ignorant men."

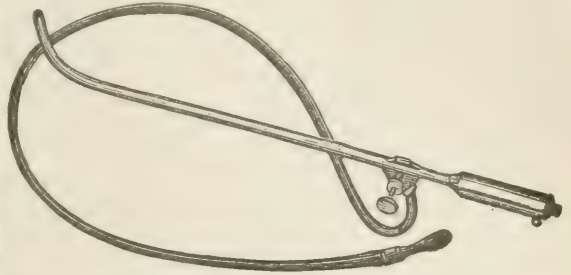
First, understand the nature of the parts diseased. Second, understand the disease you are attempting to cure. Third, understand the nature of the remedy you are making use of; and fourth, understand how to apply it. With these simple rules in view one can scarcely do harm.

ORDINARY STONE SEARCHER.

Professor Andrews, of Chicago, gives the following description of this instrument in the *Four. Am. Med. Association* for March :—The first step towards an instrumental demonstration of the presence of a stone is by the process of sounding. This operation, as performed with the old instruments, was sufficient to detect stones of ordinary size; but in cases of very small calculi, or in searching for the last minute fragments during the operation of litholapaxy a more delicate apparatus is required. To meet this necessity I devised in the year 1877 an attachment to the ordinary searcher, by which I was enabled to detect by the ear the smallest bit of calculous matter. The apparatus was shown to the Illinois State Medical Society in 1878, and figured and described in the Society's Transactions of the same year (p. 254). In the form there depicted the instrument consists of a light, hollow searcher, having a small rubber tube and ear piece attached. The searcher being introduced into the

bladder, and the ear piece placed in the surgeon's ear, the slightest contact with sand or grit becomes distinctly audible. Having subsequently discovered that a solid searcher transmits the sound as well as a hollow one, I modified the plan and appended a small clamp screw to the rubber tube, by which I could attach it at pleasure to any metallic sound whatever.

The Figure shows the apparatus clamped to Sir Henry Thompson's searcher. I have one with two tubes attached for the purpose of increasing the intensity of sound by the binaural effect, as well as to assist clinical instruction by enabling two students to listen to the sound at once.

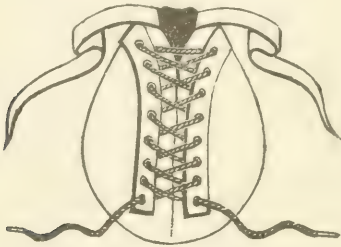


The search of the bladder, to be thorough, must be made with at least two forms of instruments, viz.: the ordinary searcher with a short beak, which can be rotated backward to explore the *cul-de-sac* behind the prostate, and the one with a very long beak to reach the front of the bladder near the pubis. I often clamp the tube to a simple britannia metal sound capable of being successively bent into several different curves as the case may require. Contrary to one's natural supposition, this soft metal conveys sound almost as well as steel. The auditory sounds are manufactured and sold by E. H. Sargent & Co., of Chicago, to whose enterprise and kindness I am indebted in the construction of many other new forms of apparatus made at my request.

I have practiced for some years another innovation, which I consider of still more importance, though I am unable to say whether I have any priority over others in that respect. I refer to the great value of using warm carbolized water during the whole operation of litholapaxy, both to distend the bladder during the crushing, and to wash out the fragments afterward. Carbolized water acts as a decided local anæsthetic, benumbing the nervous activity of the bladder, and seeming to me to greatly lessen the shock of prolonged operations; besides, it checks bleeding, and leaves the viscus in a thoroughly antiseptic condition, preventing the formation and the putrefaction of pus, and acting as a very powerful local antiphlogistic. I use it in the strength of about 1½ per cent., and am satisfied that it greatly lessens the danger of all operations in the bladder.

A SUBSTITUTE FOR STRAPPING THE TESTICLE AND THE TREATMENT OF HYDROCELE.

Dr. J. C. Warren has devised a chamois-leather bag for the purpose of exerting pressure on a small collection of fluid left in the tunica vaginalis remaining after an operation for radical cure. The bag can easily be applied by isolating that portion of the scrotum containing the testicle to be compressed and forming a pedicle, which is preserved by tightening the chamois-leather string. The bag is then laced from above downwards, and, if it has been made to fit snugly, exercises a gentle and equable pressure. If it is necessary to increase



the pressure a few turns of a common narrow roller bandage around the equator of the globular mass are all that is necessary. This bag is free from the well-known discomforts of plaster, is easily made and applied, and can be removed and re-applied by the patient himself as often as is desirable, thus avoiding excoriation at constricting points. In the single case in which it was used the effusion promptly disappeared, and has not since returned at an interval of nine months.

Dr. Warren spoke of the advantages of Dr. Levis' method of treating hydrocele by the injection of one drachm of the liquefied crystals of carbolic acid. It appears to be specially adapted to the lighter forms of the disease, is almost painless, and produces very moderate reaction, so that the private patients he had operated upon on a Saturday were able to be about again on the following Monday. In but one case had he found any perceptible discoloration of the urine, although this symptom of carbolic absorption had been carefully looked for in all his cases. He recommended the substitution of the ordinary horse subcutaneous syringe, with a trocar attachment to one of the needles, instead of the ordinary trocar and Sims' ear syringe which Dr. Levis uses. In large hydroceles of long standing the acid does not produce any perceptible effect upon the disease. He spoke of the discomforts and comparatively long confinement attending the operation by incision, even under the most careful antiseptic precautions, as laid down by Volkman. The constitutional disturbance and the local cedema, with occasionally sloughing of the connective tissue, even when the

wound has been kept aseptic, make this an operation which should be reserved for those cases only which are not amenable to other modes of treatment.

Dr. Strong spoke of the difficulty of keeping a Lister dressing on the scrotum after operation. There is always less danger of cedema when the scrotum is kept raised.

Dr. Rubin, in injecting hydroceles, uses Delano's rubber bulb syringe, as being more convenient than the cylinder syringe.

Dr. Marcy had had abscess and sloughing follow the injection of a drachm of liquefied carbolic acid crystals. One half that amount has been found to be equally effectual in curing the hydrocele, and is not accompanied by so great danger of excessive inflammation.

Dr. Cheever never attempts a radical cure in old men, but advises them to be content with tapplings repeated as often as necessary, as a low form of inflammatory cedema of the scrotum, ending in death, is described as peculiar to the aged.—*Boston Med. Journal*.

A CONSULTATION.

An only child, within whose tender life
Centre the fondest hopes of husband, wife
And many friends, seems on the verge of death;
Convulsed with pain; with fitful, rapid breath,
Clenched hands, eyes sunken, nostrils stretching wide
He scarce can count the pulse's hasty stride—
He looks at his thermometer amazed,
Its column to a frightful figure raised;
Ah, you and I have felt this anxious fear,
And wished some able counsellor were near
To aid in such extremity, or bear
Of such responsibility a share.
No time to lose, he summons to his aid
His nearest rival; time is quickly made,
And Jehu-like, with foaming steed he drives,
And at the moment specified arrives.
In manner brusque, pompous in air and style
He greets his brother with the blandest smile,
With new-found friends shakes hands with relish keen;
Happy to see them, happier to be seen.
His conversation he directs to these,
With studied effort to attract and please;
Tells of an anxious case he had last night,
Which by his skill is coming out all right;
Details his treatment in a learned way,
Bold and heroic as we sometimes say;
Consults his watch, and softly names the time
When he must see a case with Dr. Prime,
A city lady, wealthy and refined,
Attractive both in person and in mind.
His fine impressions made, he condescends
To interview the doctor and the friends;
And, ere he sees the case, states his belief
That he can soon suggest a prompt relief.
He quickly scans the case, and feigns to see
At once the lesion and remedy;
Tells of a dozen cases he has had!
Within a year with symptoms quite as bad.
And thus the farce of consultation ends;
What further he discloses to the friends
We ne'er shall know; but somehow it transpires,
He gets the case—his brother soon retires.

—Dr. Nye, *Cincinnati Med. Journal*.

TO ASCERTAIN THE COURSE OF THE SMALL BOWEL IN ABDOMINAL SECTION.—It is confessedly difficult to distinguish the upper from the lower end of a knuckle of small intestine presenting at an abdominal wound; yet it is often desirable to know this, *e.g.*, when practicing abdominal section for the relief of internal intestinal obstruction, or in attempting duodenostomy, so called. Operators have ere this passed some feet of intestine through their hands, uncertain as to whether they were proceeding upwards or downwards in the direction of the tube.

The jejunum and ileum, loosely moored to the spine by the mesentery, are the districts of the bowel usually in question. The mesentery, at its border, follows the windings of this portion of the gut, and is correspondingly complex; but, on approaching the spine, it rapidly narrows, until, at its attachment along the front of the column, its root is but about six inches in extent. This attachment of the root, extending, it will be remembered, from the left side of the body of the second lumbar vertebra to the right sacro-iliac synchondrosis, follows roughly the middle line of the body, its two surfaces facing nearly right and left.

The relation of the bowel to the root of the mesentery furnishes a sure guide to the direction of the bowel; for, if the piece of bowel which presents at the abdominal wound be held in a line with the body, and the bowel be in its true direction—*i.e.*, the apparently upper end be really so—the hand, passed along the side of the bowel and backwards towards the spine, will be guided by the mesentery—if this last be held out taut from the spine—to the same side of the spinal column. Thus, passed to the right side of the bowel, the hand will be conducted by the mesentery to the right side of the column; to its left side, if passed to the left of the bowel. Here at the mesenteric root, the hand may be passed upwards and downwards, without hindrance, along its attachment. But, should the apparently upper end not be really so, the hand passed to the right of the bowel, will be guided by the mesentery over the left side of the spine; passed to the left of it, it will be guided over to the right side. In explanation, we may look upon the mesentery as a partition dividing the abdominal cavity into two compartments, having a simple arrangement of right and left posteriorly at the spine, but complexly arranged towards the free intestinal border.

The above method has been tried, always with correct results, by several of my friends, and by myself, when making post mortem examinations. It seems to me to be worthy of trial on the living, and will, I hope, in some cases, clear away doubt.—*British Med. Journal*.

THE TREATMENT OF ABSCESSES OF THE NECK.—Dr. John A. Lidell, in a very instructive article

on this subject in a number of *The American Four. of the Medical Sciences (Med. Record)*, points out that sudden death may occur from deep-seated abscesses of the neck, or the continuance of life may be greatly endangered, much oftener than is generally supposed; and that these abscesses in the neck are more frequently attended with hemorrhages due to the opening of important blood vessels by ulceration or erosion, and by *ramollissement* consequent upon the disorders themselves, then abscesses in other surgical regions. The superior liability of cervical abscesses to the spontaneous occurrence of dangerous hemorrhages arises in part from the greater number and importance of the cervical blood vessels; but more particularly from the inanition and exhaustion, or low state of the constitutional powers, and consequent feebleness of the reparative forces, which rapidly result from most of the deep abscesses of the neck, or rather from the inability to swallow enough food to support life, and from the powerlessness to get any refreshing sleep, or even repose, with which these abscesses are oftentimes attended. The septic or toxæmic influence of the fetid secretions and exudations which present themselves in the aural and faucial cavities, in many instances, also aids materially to still further depress the patient, and weaken the reparative process of his system. These deep-seated abscesses of the neck, when allowed to run their own course, do not exhibit any tendency to a spontaneous cure; but, on the contrary, they always tend to destroy life by burrowing or spreading, etc.; and Dr. Lidell shows that the earlier they are laid open and evacuated the better for both patient and surgeon. As soon as fluctuation is discerned, the abscess cavity should, without delay, be freely laid open, the coagula turned out, the bleeding point, or source of the hemorrhage, brought distinctly into view, and the delinquent vessel itself should be ligatured on each side of the aperture in its walls. But should the ligatures cut through, the actual cautery must be applied to the bleeding point, the primitive carotid artery should be firmly compressed against the cervical vertebræ by the surgeon's thumb or fingers applied on the anterior part of the corresponding side of the neck, between the larynx or trachea and the inner border of the sterno-cleido-mastoid muscle, with force enough to press the artery backward and inward against these vertebræ, and flatten it there. Should this procedure fail, it will be advisable, especially in cases where the bleeding proceeds from tonsillary abscesses, to ligature at once the primitive carotid artery.

ALUM IN WHOOPING-COUGH.—Dr. H. Cullimore, M.D. (*Brit. Med. Journal*), says:—This is a very old and efficient remedy in many parts of the world, as well with the profession as the public. It was the first I ever used, and still, after a fair trial of most drugs, I like it best. It may be given

immediately after the cessation of the catarrhal stage, for which small doses of aconite answer best; in fact, as soon as ever the distinctive cough has appeared. I generally give it as follows, though at the same time I should like to say that the belladonna is not necessary:

R Aluminis sulph. gr. ii;
Tincturæ belladonnæ..... m iii to v;
Tinct. cinchonæ..... m xii;
Syrupi aurantii..... 3 ss;
Aquam ad..... 3 ii. M.

This is given three or four times a day for a child of four years. This mixture has a rough bitter-sweetish taste, and is much relished by children. It also answers well (without belladonna) in convalescence from broncho pneumonia attended with head-sweating and loss of appetite.

The *modus operandi* of alum is not so clear. Dr. Meigs gives a drachm in honey every ten minutes in croup till the child vomits, and in this disease prefers it to all other remedies; and it may possibly be by some action short of emesis that it acts in whooping-cough. I have, however, myself never given it in such doses (which could not be long continued), and am inclined to attribute its utility to its astringent, bracing, and tonic action on the blood and on the mucous membranes of the stomach and air-passages.

Whooping-cough proves fatal in most cases by sub-acute catarrhal bronchitis—a condition which small doses of alum are eminently calculated to prevent and restore.

It is possible, also, from its antiputrefactive properties, that it may exercise some deleterious influence on the *materies morbi*, or what I may perhaps call the germs of the disease. However this may be, alum is an excellent remedy. In the combination above given, I have almost invariably found it to lessen the cough, increase the appetite, strengthen the child, and in the end cure the disease.

Sometimes, however, a hacking spasmodic cough preventing sleep, which no drug seems to relieve, occurs. Here, one or two teaspoonfuls of brandy, or less according to age, with a double or fourth part of hot water and very little sugar, answers remarkably well.

FORCED RESPIRATION IN PHTHISIS.—Dr. J. Solis Cohen has been favored by his friend, Dr. John C. Berry, of Okayama, with the following summary of an article on Forced Respiration, by Dr. Kashimura Seitoku, of Tokiyo, from the *Koi Geppo*:

Reference is first made to the prevalence of the disease in Japan (twenty-four per cent. of all the deaths being due to consumption of the lungs); on the importance of treating the disease early ("beneficial effects only following early treatment") and the uselessness of much of the treatment now

generally advised. "Creasote, benzoate of soda, salicylate of soda, etc., are all quite useless," "while cod liver oil and malt, iron and malt, and tonics generally, are of little or no use."

"The plan I propose requires no medicines, no apparatus, no money, no physician, no nurse." * * * "It is simply to observe forced respiration twice daily, breathing about one hundred times at each exercise, and compressing and expanding the chest walls, after the method of Gerhart. During this exercise, the arm corresponding to the sound lung should be pressed against its side, while that corresponding to the side of the diseased lung should be extended high above the head during respiration, and lowered and pressed firmly against the side and front of the chest during expiration."

"Instead of the above, the author first adopted the plan of having the patient swing heavy weights, but as this frequently gave rise to hemorrhage it was abandoned for the more moderate and efficient exercise above referred to. The swinging of weights, however, is thought to possess advantages, if not too vigorously observed."

"In contraction of the lung from pleuritis, the position in sleep should be on the *well* side—the diseased lung thus being placed uppermost in order to admit the air freely."

Two illustrative cases are then given.—*Philadelphia Polyclinic*.

DEEP AND RAPID BREATHING.—Breathe deeply and rapidly for two or three minutes and you will be surprised how long you can "hold your breath" without even wishing to breathe. This is probably the secret of the "man-fish" who frequently exhibits himself in museums, etc. His feat is to remain under water an astonishing length of time.

The composition of nitrous oxide (laughing gas) is the same as common air, except that it has a larger proportion of oxygen; and its anæsthetic effect is thought to be due to its oxygen. Deep and rapid breathing, by supplying an excess of oxygen to the blood, has been found to be an anæsthetic of considerable value. Many operations rendered painless by this measure have been reported. We wish to suggest that this forcible "ingestion" (oxygen is a gaseous food) may be made a valuable therapeutic procedure. Habitual deep breathing will doubtless benefit many cases of anæsmia, malnutrition, etc., provided that the air be pure. Indeed, we can scarcely imagine any abnormal condition that might not be benefited in this way. Those persons who lie awake at night and toss about restlessly, vainly trying to go to sleep, will find deep and rapid breathing for several minutes to be a sweet and grateful composer.

Forced feeding has recently been very successful in the treatment of nervous and other maladies.

SURGICAL FOLLIES.—The *Med Age* gives the following abstract of a paper read by Dr. J. B. Roberts, Philadelphia, before the Westchester Medical Society, and published in the Polyclinic. He points out what he considers to be follies in connection with surgical procedures. He calls them the ether folly, the incision folly, the sponge folly, the styptic folly, the suture folly, the adhesive plaster folly, the dose folly, etc.

The ether folly is almost universal. It consists in allowing the inhalation of atmospheric air with the vapor of the ether, as it is proper to do when giving chloroform. In giving ether the napkin holding it should not be removed from the patient's nose and mouth. When it is necessary to replenish the anæsthetic the corner of the napkin should be turned up and a fluid ounce of the ether dashed upon it, or it may be poured on the outside of the napkin and covered with a large dry towel. The pure ether vapor must alone be inhaled to secure its best effects. The only exception to this rule is when blueness and congestion of the face occur as a result of spasm of the respiratory muscles. Usually one deep inspiration will be sufficient to relieve this, when the napkin should be immediately replaced. Squibb's ether is in no way superior to that of other reputable manufacturers.

The incision folly consists in making a cramped cutaneous incision, instead of one sufficiently large to fully display the tissues needing examination. A cut of the skin three inches long is no more dangerous than one two inches long. In opening abscesses a free cut is more satisfactory than the mere puncture or button-hole incision.

The sponge folly consists in the employment of sponges which have done previous service. They are seldom or never properly free from septic matter. To obviate this danger napkins or towels are to be employed instead of sponges. Japanese paper napkins answer a very useful purpose. Absorbent cotton is valuable but it is expensive, and besides it is apt to leave filaments entangled in the wound.

The styptic folly is also a very common one. Alum, tannin, and that vilest of all styptics, Monsel's solution, prevent or delay union by first intention by irritating the edges of the wound and preventing their coaption. Except when a large vessel is severed pressure is all that is demanded. When such a vessel is divided ligation, torsion or acupressure should be employed, but under no circumstances styptics.

The suture folly. The old idea that sutures should not be employed in the scalp has been long exploded, but still another folly exists in connection with sutures, and that is that silver wire only should be employed for suturing purposes. Iron wire is equally valuable and much less expensive. A nice iron wire can be bought for five cents a spool. If it becomes a little rusty, it can be rubbed

clean in a moment, should the operator object to the presence of a small amount of oxide of iron in the wound.

The adhesive plaster folly is prevalent. The enveloping of a stump or the covering up of an incision with adhesive plaster prevents drainage, is uncleanly and does no good. Adhesive plaster has little or no value in surgery, except for making extension, and preventing motion in cases of fracture.

Sponges, styptics, and silver wire are useless and worse than useless, and their banishment will be a long stride in the progress of surgery.

The dose folly consists in the exhibition of an insufficient quantity of medicine. It should more properly be called the *small dose* folly. Of what use is a sixteenth or an eighth of a grain of morphia to a man in severe pain? Give him a quarter or even a half grain, and repeat if necessary. And what is true of morphia is true of all other drugs—quinine, atropia, strychnine, digitalis, mercury, pilocarpine, etc.—they must be given with a bold hand to produce their effect. First, be sure of your diagnosis and then go ahead. Many surgeons fail to cure because of the tentative use of drugs which comes of uncertainty of diagnosis.

Another surgical folly is the local use of nitrate of silver for the intended destruction of a virus or for the disintegration and removal of fungous or malignant tissue. Nitrate of silver, though popularly called "caustic" is not a caustic; it is a mere irritant, scarcely more active than tincture of iodine. The caustics to be used by surgeons for the purposes mentioned are chromic, nitric, carbolic and acetic acids, potassa and similar active drugs and the hot iron. Under many circumstances the best *caustic* is a sharp scalpel.

NITRITE OF AMYL IN URÆMIC ASTHMA.—Dr. S. C. Smith, of Halifax, in the *Brit. Med. Jour.*, June, 1883, p. 1115, in referring to the usefulness of nitrite of amyl in allaying the paroxysms of uræmic asthma, says that in its very power lies its danger; for it often gives such relief, even in desperate conditions, that a feeling of false security is apt to be engendered, and thus, instead of the asthma being accepted as a most urgent warning of danger, the facility of getting relief is taken as a permission to throw aside restraint. The author points out that there are several kinds of dyspnoea but only in one group of cases does nitrite of amyl produce any relief, and those are attacks of cardiac dyspnoea, due to failure of the heart; in these cases the seriousness of the attack is often overlooked, and the ease so rapidly obtained should not be taken as proving the neurotic origin of the attack, the case being really one of failing heart; hypertrophy has done what it can, and is no longer able to overcome spasm of the arterioles. A warning ought to be taken, so that a life free

from worry and excitement may be lived by the patient, with careful attention to diet and regular habits, and the steady employment of small doses of iron and digitalis.—*The London Med. Record.*

BLISTER FOR COUGH.—Prof. James Tyson, M.D., of the University of Pennsylvania, in the *Medical Times*, says: The very best medicine, and often the only one which will accomplish the result, is a blister. We have now in our wards a case of consumption in which the cough was most troublesome for six or eight weeks, and cough medicines of all kinds had failed; but in twenty-four hours the symptom was relieved by a blister.

[Better than the blister, is this:

R Morph. acetat. gr. iij;
Acidi hydrocy. dil. ʒ j;
Syr. tolut. ʒ iij.

M. Ft. sol. S. A teaspoonful as often as cough demands.

The medicine should be kept in a dark bottle well stoppered. Some cases will require more and some less morphia and prussic acid, but this is a benign remedy. The blister and croton oil are well for pain, but should be a last resort for cough. Where mucous secretion is deficient, iodide of potassium is the remedy. Where strength to raise the sputa is deficient, ammonia, alcohol, and coffee are the remedies.]—*Louisville Med. News.*

COMPOUND FRACTURE OF THE HUMERUS INVOLVING THE SHOULDER JOINT.—Dr. L. A. Stimson, (*New York Surg. Soc.*) presented a man, thirty-five years of age, who fell two stories, striking his arm, while on the way down, upon a railing, and producing a compound fracture of the upper end of the humerus, communicating largely with the shoulder joint, the wound extending from the coracoid process across the upper part of the arm. The wound was washed with a bichloride solution, one to two thousand, partly closed by sutures, two drainage-tubes were inserted, and anti-septic gauze was applied. The interest in the case was confined to the plaster dressing which was used. It was a combination of plaster dressing upon the arm and a plaster jacket upon the body, united by three iron cross-pieces, which held them so firmly that the patient could be moved or turned in any direction without producing pain. Rapid recovery took place with a movable joint.—*N. Y. Med. Four.*

EXTIRPATION OF CANCEROUS UTERUS.—Dr. A. Reeves Jackson (*Gynecolog. Trans.*) summarizes an investigation of this subject by the following propositions:

1. Diagnosis of uterine cancer cannot be made sufficiently early to insure its complete removal by extirpation of the uterus.

2. When the diagnosis can be established, there is no reasonable hope for a radical cure; and other

methods of treatment far less dangerous than excision of the entire organ are equally effectual in ameliorating suffering, retarding the progress of the disease, and prolonging life.

3. Extirpation of the cancerous uterus is a highly dangerous operation, and neither lessens suffering—except in those whom it kills—nor gives reasonable promise of permanent cure in those who recover. Hence it fails in all the essentials of a beneficial operative procedure, and should not be adopted in modern surgery.

DICTIONARY OF SURGERY.—Mr. Christopher Heath has undertaken to edit for Messrs. Smith & Elder, a "Dictionary of Practical Surgery," on the lines of Quain's Dictionary of Medicine, which has scored such a satisfactory success. The new dictionary is to be a compendium of the practice of surgery of the present day, readily available for reference by the busy practitioner, and it is hoped that it will be published within two years from now. The articles will be signed and will be expressed as concisely as possible, historical details being omitted, the question of pathology only discussed when absolutely necessary. The profession will look forward with great interest to the publication of this work, which is much wanted, and which will no doubt fully come up to the expectations which all who know its editor will have formed of it.—*Med. Times and Gazette.*

THE DRY MOUTH OF THE LITHOMIST.—At a recent clinic, Prof. Brinton said that an attendant of lithotomy is dryness of the surgeon's mouth, similar to that produced by belladonna; and Prof. S. D. Gross remarked: "It is peculiar to the operation for stone; I have often felt it." A thesis showing the relation of a stone in one man's bladder to the salivary glands in another man's mouth would probably take the Lea prize.—*Col. and Clinical Record.*

HOPE'S MIXTURE.—This mixture is one commonly employed in the Southern States for simple diarrhoea.

R—Aqua camphoræ, ʒ iv.
Tinct. opii, gtt. xl.
Acid nitricum, gtt. iv.—M.

SIG.—Tablespoonful every three hours.—*Med. Student.*

COUGH MIXTURE.

R—Ammon. mur., ʒ ij.
Morph. sulph., gr. j.
Tr. aconit. rad., ʒ xvj.
Ext. belladon., fl. ʒ v.
Ext. glycyrrh., ʒ j.
Syr. tolut., ʒ j.
Aq. ad., ʒ iv.—M.

SIG.—ʒ j. every three or four hours.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science
Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & CO., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, MAY, 1884.

The LANCET has the largest circulation of any Medical Journal in Canada.

COMPARATIVE DURATION OF LIFE.

Mortality tables are now so full, complex and accurate as to deserve to be ranked as a science. Several circumstances have combined to bring about this degree of perfection, the principal of which are the needs of insurance companies. Capital is ever wide-awake, and wherever we find countless millions engaged in fierce competition, we may rest assured, that neither money nor labor will be spared to explore the particular field of operations. The vast and growing interests of life insurance, and the keen competition which has grown up of late years, demand the fullest possible information regarding the duration of life, under all the phases and conditions of modern civilization. Governments also are important contributors to this statistical fund. Sanitarians too have borne a conspicuous part in the work. The net result is, that man's life from the cradle to the grave is mapped out, defined and tabulated with such mathematical precision as almost to make life and money convertible terms. Even a superficial examination of the tables reveals some queer and interesting facts. We shall not proceed far in our study of them before we see the bottom dropping out of some cherished idea, and discover the wide difference between facts and fancies.

The preservation of life being nature's first law, it is pleasing to learn that the average age of man is on the increase. During the last half century the duration of life in England has advanced seven per cent. There is great reason for believing that another half century will add at least seven per

cent. more. From this it would appear that man, in some measure at least, presides over the external conditions which conspire to cut short his earthly pilgrimage. Here we naturally recall the words of Scripture, "There is an appointed time for man upon earth," and that interpretation of these words which attaches a fatal fixity to the duration of human life. The hackneyed phrase, "His time was come," is often used to condone neglect on the part of relatives, or to cover the retreat of the physician, but it is more often used to express belief in a determinate limit to man's time upon earth.

That mortality is decreasing, and longevity becoming more and more assured, are great and pleasing facts, whatever may be the cause of final dissolution, whether the accidental pressure of external causes, want of physical organic harmony, or a predestined purpose. It is perfectly plain that the food we eat, the clothes we wear, the houses we live in, the air we breathe, and the life we lead, are all elements of life or death, according as they are good or bad. If not, then, vain indeed, is all medical and sanitary improvements, and in vain have the wheels of science been revolving all these weary years. Let us rejoice that disease is no longer regarded as a special and mysterious providence. Men of all shades of opinion now regard it as a thing very largely preventible, and in no small measure subject to human control. Superstition and dusty dogmas die hard, but they must yield before the glare of universal knowledge. Health and life, and not disease and death, are what mankind ardently wish for. The process of dying stands correlated to the process of living, yet the impulse to ward off death is so strong, that life is the first law of our nature.

"'Tis life whereof our nerves are scant,
Oh, life not death, for which we pant!
More life and fuller that we want."

After the general fact that the duration of life is increasing, perhaps the next most interesting information gathered from mortality tables, relates to the view we get of the beginning and end of life. Viewing one end of the bridge of life as pictured by Addison in the Vision of Mirza—a bridge in the midst of the tide, having three score and ten arches, with several broken arches, making a total of about one hundred—viewing this bridge at one end we see it covered with mil-

lions of children, among whom are more boys than girls. Extending our vision to the other end we behold a handful of aged people, the number of women exceeding that of the men. This latter fact, woman's longevity exceeding man's, is one of the things that never would occur to an ordinary mind. We regard woman as the weaker vessel, exposed to the trying ordeals of maternity, the victim of many fatal diseases from which men are exempted, and needing and receiving man's love and tenderest care. This fact is all the more surprising when we remember that the males start out with a surplusage of nearly ten per cent., even though half of this is lost before life is really begun, the number of still-born males greatly exceeding that of females. The first five years show a male mortality of 7.216 per 1000 to 6.016 of the females. During the first ten years 46½ per cent. of all born pass off the stage. During this period boys suffer greater mortality than girls. The period between ten and twenty years, we are told, is the only period in which there is an excess of female mortality. This is the period of sexual development and excitement. Between fifteen and twenty, females are peculiarly exposed to phthisis. Between twenty and forty is the highest period of mortality in adult life, in both sexes; it is also the period of child-bearing, and the time when we would naturally look for an excess of female over male mortality, but the figures actually show the reverse of this. At the close of this period, namely, between 35 and 40, Finlayson shows that out of 100,000 persons there will die 7042 males and 6959 females, and between 40 and 45, Ostend says the numbers are 11,107 males and 7,094 females. Marriage increases the duration of life of women. The mortality resulting from child-bearing, Tarnier puts as low as one-third of one per cent. The climacteric period, contrary to general belief, is not attended with unusual mortality. The "change of life" produces functional derangements, we know, but the belief that women are more liable at this period to be attacked by fatal diseases is clearly and fully contradicted. On arriving at the farther end of the bridge, we still find women numerically stronger. The number of women who live to over 80 are about as 2 to 1 compared with men. The statistical tables of New York for ten years, among deaths of centenarians, give seventy-two females and nineteen

males. Women's dangers in child-bearing are more than counterbalanced by the injuries to which man finds himself exposed in the pursuit of his daily avocation. How woman manages to remain "to hold the fort" after her lord and master has made his exit, affords food for further reflection.

MEDICAL ASSOCIATION MEETINGS.

The association meetings of the profession this year bid fair to outrival those of any other year in the history of medicine. Both at home and abroad there is every prospect of large gatherings and interesting meetings. The meeting of the British Association for the advancement of science, will be held in Montreal, beginning on the 27th of August, and it has been arranged by the President (Dr. Sullivan), and the local committee, that the meeting of the Canada Medical Association, which is also to be held in Montreal this year, shall take place on the 25th, 26th, and 27th, so as immediately to precede the former meeting, and thus give members an opportunity of seeing and hearing the leading scientific men of Great Britain. A large number of the members of the British Association above referred to, are medical men, and it is expected that many of them will attend the meeting of the Canada Medical Association. This will greatly enhance the interest in both meetings, and we trust the members of the Canada Medical Association will show their appreciation by being present in large numbers, so as to make the meeting a success in every respect. The Ontario Medical Association, under the presidency of Dr. Daniel Clarke, Toronto, will hold its annual meeting in Hamilton on the 4th and 5th of June, and promises to be more than usually successful. A number of delegates are expected from various kindred associations, among others Drs. Hopkins, Vanderpool and Howe, from the New York State Society. Our brethren from the neighboring Republic will be cordially welcomed by the members of the Association, whom we hope to see present in large numbers.

The American Medical Association, under the presidency of Dr. Austin Flint, sr., will hold its 35th annual meeting in Washington, commencing on the 6th of May. This is the first year since the establishment of the Journal of the Association and some degree of interest will be manifested in the

financial success of the undertaking. The character and general matter of the journal itself, it must be conceded, has not met the just expectations of its friends, and some change will require to be made in the management if the journal is to occupy the position which its projectors intended.

The Baltimore and Ohio railway will run a special train from Chicago to Washington, on Sunday May 4th, at 3 p.m., at single fare, for the round trip.

The fifty-second annual meeting of the British Medical Association will be held in Belfast, July 29, 30, 31, and August 1st, under the presidency of Prof. Cuming, M.A., M.D., of Queen's College, Belfast. The address in medicine will be delivered by Sir Andrew Clark; in obstetrics by Geo. H. Kidd, M.D., of Dublin, and in physiology by Prof. Redfern, M.D., Belfast. The time of the meeting has been fixed so as not to interfere with the meeting of the International Medical Congress, which meets in Copenhagen on the 10th of August. Visitors after attending the meeting of the British Medical Association, will have ample time to travel to Copenhagen. A steamer will leave Hull (England), on August 2nd and 9th, and Leith (Scotland), on August 5th, for Copenhagen. There are other routes, but these will be found most convenient.

PUBLIC HEALTH.

The profession has displayed unusual activity in and about the Parliament buildings in Ottawa lately, with reference to the question of Public Health.

As a result of the deputations, representing the profession throughout the Dominion, that have interviewed the Government during the past few years, a scheme is in force in all the large towns for collecting mortuary statistics as a beginning in that important work. Overlooking this fact, and ignoring (though not intentionally) the body that has hitherto conducted the work, a meeting of the profession in Ottawa was recently held, at which a resolution was passed favoring the plan of collecting statistics referred to in our last issue, and a delegation was appointed to wait on the government and bring it under their notice. The plan proposed is an enlargement of the one now in force—its work being extended to the rural districts, the returns to be made by a practitioner in each district.

During the session of the Sanitary Convention a meeting of the visiting and resident physicians was held and the subject fully discussed. Upon the information that the Public Health Committee of the Canada Medical Association was in consultation with the government and at present was formulating a scheme to be presented at the next meeting to be held in August, the following resolution was passed and communicated to the government:

"That further consideration of any legislation in connection with public health be deferred until after the next meeting of the Canada Medical Association, in order to give the committee of that body time to report."

A third deputation subsequently interviewed the members of the government representing the Quebec Sanitary Association, which has recently been formed among the French physicians of that Province. The object of this deputation was to solicit state aid for a French journal similar to that received by the journal published in Ontario.

It is very much to be regretted that so many deputations, representing separate interests, should wait upon the government. As long as this continues nothing will be accomplished. It would be infinitely better were all to unite with those who have hitherto been recognised as the leaders in this movement. Their representations would then command that attention to which they are so fully entitled.

TRINITY MEDICAL COLLEGE.—The following gentlemen have successfully passed the professional examination in the different years:

FELLOWSHIP DIPLOMA.—W. M. Brown, *Gold Medallist*, E. H. Williams, *1st Silver Medallist*, G. Fierheller, *2nd Silver Medallist*, S. A. McKeague, G. A. Bingham, G. L. Airth, R. Ovens, A. D. Lake, *Certificates of Honor*; J. E. W. Anderson, James E. Brown, O. M. Belfrey, J. C. Bell, D. A. Carmichael, W. J. Chambers, J. M. Cochrane, S. M. Dorland, P. N. Davey, A. V. Delaporte, E. T. Eede, D. Gow, A. Gillespie, E. N. Hall, W. S. Harrison, G. L. Johnston, T. H. Johnston, J. Johnston, T. M. Lawton, T. H. Mott, J. Standish McCullough, J. Stuart McCullough, T. McCullough, C. J. McIntyre, A. McKillop, T. Ovens, J. Park, W. E. Sprague, A. K. Sturgeon, A. Scott.

PRIMARY.—E. H. Williams, S. Scott, A. Graham, R. Lucy, W. H. McKague, O. M. Belfry, E. N. Fere, *Certificates of Honor*; J. M. Simmons, F. H.

Brennan, C. Lapp, D. C. Throop, W. H. Charlesworth, J. McC. Cleminson, W. V. Lynch, N. Allen, G. J. Dickison, J. G. Harper, H. J. Roberts, C. N. Sanford, O. Totten, P. E. Doolittle, J. F. Housberger, A. F. Bauman, C. S. Haultain, H. W. Hoover, W. W. Hay, L. Brock, A. M. Ewing, W. A. Williamson, A. B. Eadie, J. Evans, J. J. Cassidy, H. W. Darrell, W. W. Coldham, T. S. Farrar, R. West, W. W. Van Velsor, E. A. Fillmore, F. C. Hood, A. K. Sturgeon, A. C. Woodley, J. S. McCullough, J. H. Kilgour, W. H. Hamilton, W. O. Scott.

The following have passed on three or more subjects, H. S. Bingham, C. E. Stacey, T. M. Robinson, W. A. Wilson, and H. J. Caldwell.

SCHOLARSHIPS.—*First Years' Scholarship*.—1st, Jas. McLurg, 2nd, John McLurg; *Certificate of Honor*, J. Hamilton; *Second Years' do.*, S. Scott; *Third Years' do.*, J. R. Logan.

MCGILL UNIVERSITY, MONTREAL.—The following is a list of the successful candidates in this University :—

M.D.; C.M.—W. A. Ferguson, B.A. *Holmes Gold Medallist*; J. P. McInerney, *Prizeman*; G. A. Graham, R. F. Ruttan, B.A., W. G. Johnston, E. J. Elderkin, T. B. Davies, *Honorable Mention*; J. L. Addison, Jos. A. Barrett, Hy. J. Clarke, John R. Church, Sheldon E. Cook, John A. Duncan, C. E. Gooding, Jas. A. Hutchison, C. H. Johnson, Patrick N. Kelly, Thos. H. Landor, J. H. McLellan, Wm. McClure, G. N. McLean, John C. Meahan, David B. Merritt, W. M. F. Nelson, Timothy O'Brien, Wm. Porteous, W. Scott Renner, L. D. Ross, Geo. B. Rowell, E. H. Smith, W. A. De W. Smith, H. E. Smyth, Felix D. Walker, S. F. Wilson, M.A.

PRIMARY.—S. Gustin, *Prizeman*; J. Elder, *Sutherland Gold Medallist*; N. G. Powne, H. S. Birkett, J. A. Kinloch, J. Elder, W. W. White, W. J. McCuaig, W. C. Crockett, G. H. Raymond, John L. Duffet, C. W. Wilson, F. J. Seery, G. B. Rowat, A. R. Turnbull, E. P. McCollum, and G. F. Palmer, *Honorable Mention*; J. H. Armitage, D. A. Cameron, D. Corsan, J. L. Clark, M. A. Craig, W. W. Doherty, Thos. M. Gairdner, J. B. Gibson, Geo. J. Gladman, J. H. Y. Grant, P. H. Hughes, H. J. McDonald, Thos. G. McGannon, J. W. McMeekin, J. M. McKay, A. T. Platt, W. P. Pringle, A. Raymond, F. D. Robertson, A. T. Schmidt, W. A. Smith, F. J. White, D. J. Wishart, A. N. Worthington.

Botany prize, 1st year, N. E. Powne and J. E. Gray; *Practical Anatomy*—1st year, D. L. Ross, 2nd year, H. S. Birkett; *Pathology*—E. C. Wood, *Prize*, F. G. Finley, *Honorable Mention*.

TRINITY UNIVERSITY.—The following is a list of the candidates who received degrees and honors

at the recent convocation at this University. The gentlemen were all students of Trinity Medical School.

M.D., C.M.—E. H. Williams, *University Gold Medallist*, W. M. Brown, J. L. Davidson, G. A. Bingham, *Certificates of Honor*; G. Fierheller, E. A. Hall, G. L. Airth, J. Johnston, J. Standish McCullough, S. A. McKeague, F. H. Johnston, D. Gow, A. Gillespie, S. M. Dorland, W. S. Harrison, E. J. Eede, J. M. Cochrane, A. D. Lake, A. McKillop, W. E. Sprague, Jas. S. McCullough, R. Ovens, T. Ovens, G. L. Johnston, W. J. Chambers, P. N. Davey, T. H. Mott, T. McCullough, O. M. Belfry, J. C. Bell, E. Furrer, A. V. Delaporte, J. E. Brown, J. E. W. Anderson, J. Park, E. A. Fillmore, J. H. Kilgour, A. V. Sturgeon, J. C. McIntyre, T. M. Lawton, D. N. Carmichael, W. H. Hamilton, W. O. Scott, A. Farncombe.

The following gentlemen who had previously received the degree of M.B. were also admitted to the degree of M.D., C.M.—W. H. Macdonald, F. Canfield, A. J. Gaviller, W. W. Geikie, W. T. Harris, D. McLeod, H. Robertson, A. M. Baines, T. C. Cowan, A. Davidson, S. W. Lamoreaux, H. Meikle, T. McK. Milroy, J. C. Mitchell, J. B. Gullen, E. M. Hoople, E. B. O'Reilly, J. T. Sutherland, E. R. Wood.

VICTORIA COLLEGE.—The following gentlemen have passed the professional examination in this University :

M.D., C.M.—A. C. Smith, G. H. Carveth, H. Bascom, C. M. Forster, T. W. Simpson, G. A. Cherry, J. E. Elliott, H. S. Martin, D. Campbell, E. F. Hixon, L. G. Langstaff, A. Sangster, S. E. C. McDowell, A. T. Rice, C. W. Hunt, G. S. Wattam, J. H. Joliffe, J. O. Orr, W. A. Robertson, J. W. Campbell, A. Broadfoot, E. Beemer, J. R. Phillips, C. W. Chaffee, J. H. C. Willoughby.

PRIMARY.—W. J. Parry, J. E. Picard, W. C. Heggie, H. A. Wright, W. C. McKinnon, W. J. Teasdale, J. A. Rutherford, J. R. Dales, D. M. Williams, W. H. Wright, G. Siminton, C. E. Lawrence, L. L. Hooper, C. J. Smith, J. M. Forster, P. P. Park, G. Sanson, C. A. Hodgetts, E. E. King, G. A. McDiarmid, L. G. Smith, A. McGilivray, T. J. McDonald, S. West, R. J. Wood, A. B. Riddell, W. R. Baker, C. J. Hastings.

COLLEGE OF PHYSICIANS AND SURGEONS, ONT.—The following candidates have successfully passed the Council examination :—

FINAL.—J. L. Addison, J. E. W. Anderson, G. A. Bingham, Elizabeth Beatty, F. D. Canfield, G. H. Carveth, J. W. Clerke, D. Campbell, J. M. Cochrane, E. M. Cook, R. Coughlan, W. N. Davis, H. R. Duff, J. S. Draper, J. E. Elliott, G. Fierheller, C. M. Foster, R. N. Fraser, J. Ferguson,

2. C. Fielde, W. R. Hall, E. F. Hixon, W. H. Hamilton, C. W. Hunt, John Herald, E. A. Hall, 3. L. Johnston, John A. Jones, F. H. Johnston, 7. D. Kent, L. G. Langstaff, A. D. Lake, H. S. Martin, T. H. Mott, A. F. McKenzie, Alice McJillivray, J. O. Orr, T. Ovens, J. Park, J. W. Paterson, A. F. Pringle, L. G. Routhier, W. N. Robertson, A. T. Rice, R. F. Rutan, W. O. Scott, G. Shoults, A. Sangster, R. A. Smith, W. E. Sprague, 3. Stewart, J. Spence, D. M. Staebler, R. L. Stewart, . E. Stirling, Elizabeth Smith, H. E. Webster, W. Young.

PRIMARY.—J. E. W. Anderson, A. W. Bigelow 2. M. Bateman, C. H. Britton, H. S. Birkett, L. Brock, John Barber, F. D. Canfield, E. M. Cook, . J. Cassidy, H. C. Cunningham, L. F. Cutten, J. M. Gleninson, W. H. Charlesworth, W. N. Davis, P. E. Doolittle, J. R. Dales, A. W. Dwyer, G. J. Dickson, A. H. Edmison, E. H. Earle, W. M. English, A. 3. Eadie, D. D. Ellis, C. M. Foster, Jas. Ferguson, H. B. Ford, E. C. Fielde, J. H. Y. Grant, A. Graham, W. R. Hall, W. H. Hamilton, H. J. Hamilton, V. C. Heggie, P. H. Hughes, W. W. Hay, D. R. Johnston, John A. Jones, W. A. Kyle, W. V. Lynch, 2. Lapp, A. T. Little, Robt. Lucy, W. Logie, M. Mather, L. J. Mothersill, S. J. Mellow, J. Marty, F. H. Mott, W. H. McKague, G. McKenzie, N. McCormick, C. T. Norcker, A. B. Osborne, J. Park, J. W. Peaker, J. E. Pickard, G. A. Peters, W. T. Parry, L. G. Routhier, A. T. Rice, D. G. Russell, J. A. Rutherford, Helen Reynolds, W. O. Scott, Geo. Shoults, A. M. Shaver, G. Simenton, 3. Sanson, D. M. Staebler, C. F. Snelgrove, C. M. Sandford, C. E. Stacey, W. E. Sprague, J. A. Stirling, Stuart Scott, R. A. Smith, C. J. Smith, J. N. Simmons, L. W. Thompson, O. Totten, G. Veitch, W. A. Wilson, W. H. Wright, D. J. G. Wishart, W. J. Weekes, F. Winnett, W. J. Young.

ASSESSMENT DUES.—The Ontario Medical Council is now taking active measures to collect the arrears of assessment. No doubt the Council feels some reluctance in taking active steps, as the members of the College, in arrears, will be put to unnecessary expense, as happened with the cases that were placed in court for collection a short time ago, the costs in some cases amounting to as much as the claim. The clause in the act bearing on this point (sec. xxvii.) reads as follows :—" Each member of the College shall pay to the Registrar, or any person deputed by the Registrar to receive it, such annual fee as may be determined by by-law of the Council, not less than one nor more than two dollars, towards the general expenses of the College, which last mentioned fee shall be payable on the first day of January, in the year in which

the same is imposed, and such fee shall be deemed to be a debt due by the member to the college, and be recoverable with costs of suit, in the name of the College of Physicians and Surgeons of Ontario."

PERPETUAL INJUNCTION.—In the U. S. Circuit Court, Maryland, it was decreed, on the 10th of March, 1883, that a perpetual injunction be issued against Louis E. Wetter, and others, restraining them from imitating the labels of the Rumford Chemical Works. It was also decreed that the plaintiffs be entitled to receive the profits which had been diverted by reason of the infringement, and the defendants were ordered to pay all costs. Not long since, several parties were heavily fined for violating the injunction of the Supreme Court restraining all persons from offering for sale "Acid Phosphate" (so called) in any package which shall be a substantial or colorable imitation of Horsford's Acid Phosphate.

MALTOPEPSYN.—We notice with pleasure the large and increasing demand for maltopepsyn by the medical profession, and congratulate Mr. Hazen Morse upon having met with such gratifying success. Maltopepsyn is undoubtedly one of the most valuable aids to digestion we have, which fact has been attested by most of our leading practitioners. It has also met the approval of the profession in England, some five thousand bottles having been used there during the past year. We cordially recommend it to our medical brethren as a thoroughly reliable remedy, and valuable in the treatment of cholera infantum, and other infantile ailments, etc.

A CAUTION.—Dr. Walton, of Parry Sound, sends us a letter cautioning his brethren in the profession against an advertisement in the Toronto papers, stating that there is a good opening in that place. Two medical gentlemen have already, at considerable expense, visited the place, and after a stay of a few days, left in disgust. Parry Sound is a small village on the Georgian Bay, and there are not upwards of forty farm houses within a radius of ten miles. The motives which prompted the insertion, he avers to be mere personal spite and political animosity on the part of a certain individual.

CALCIUM SULPHIDE IN DIABETES.—This remedy has been introduced in the treatment of diabetes

mellitus. In an article in the *N. Y. Med. Journal*, Dr. Caldwell speaks in very high terms of its efficacy and alludes to other physicians who have used it with excellent results. Dr. N. C. Husted, who was himself afflicted with the disease made a complete and lasting recovery under its use. Drs. Flint, Lellman and others have also had good results from its administration in this affection.

CHLORIDE OF SODIUM IN PLEURITIC EFFUSION.—A case was reported recently in the *British Med. Journal*, in which the rapid absorption of pleuritic effusion had been accomplished by the administration of half-drachm doses of chloride of sodium every hour. All fluids were at the same time forbidden the patient. There was great dyspnoea with cyanosis and the patient refused aspiration. Improvement under the above treatment was noticeable within two hours, and in six or eight hours the cyanosis had disappeared entirely.

ELECTRIC BATTERIES.—The Jerome Kidder Manufacturing Co., of 820 Broadway, New York, received the "Medal of Superiority" from the American Institute, in the fall of 1883, over three competitors, for their superior Electro-Medical Apparatus. This old established house needs no commendation for the excellence both of design and manufacture, which render their machines a standard of quality all over the country.

HOT MILK AS A RESTORATIVE.—A writer in the *Medical Times and Gazette* recommends the use of hot milk as a restorative. Milk when heated above 100° F. loses its sweetness and density, but has a most beneficial influence over mind and body when exhausted by labor or mental strain. Its effects are more invigorating and enduring than those of alcoholic stimulants.

HOT LEMONADE FOR DIARRHŒA.—Some people prefer hot lemonade to the usual form, but it is only recently that we have seen it recommended in diarrhœa. Dr. Vigouroux recommends a glass of hot lemonade every hour, or half hour, as an easy, agreeable, and efficient treatment for diarrhœa.

OPIUM IN ABORTION.—Prof. Parvin, of Philadelphia, says that the best mode of giving opium to prevent abortion is by the rectum. He gives from twenty to thirty drops of laudanum, and repeats it as often as necessary.

RESIGNATIONS.—Prof. Alfred Stillé has resigned the chair of Materia Medica and Therapeutics in the University of Pennsylvania, after twenty years incumbency. Dr. D. Hayes Agnew has resigned from the staff of the Pennsylvania Hospital.

The citizens of Montreal having subscribed \$50,000 towards the endowment fund of McGill Medical Faculty, Hon. D. A. Smith has fulfilled his promise of granting \$50,000 to the same object.

CORONER.—Dr. D. M. Fisher, of Warton, has been appointed coroner for the County Bruce.

The Death of Prince Leopold.

In common with our fellow-subjects at home and abroad, it becomes our painful duty to record the death of Prince Leopold, Duke of Albany, the youngest son of our beloved Queen. The sympathy for Her Majesty and the bereaved Duchess which his sudden death has evoked, shows the deep loyalty and affection of the nation towards the Royal family. The late Prince was especially one to whom the nation looked with assurance of ready aid in all questions involving moral and intellectual progress. No authentic report of the cause of his sudden demise has as yet been published, and no autopsy appears to have been made. It has been currently reported that he was the subject of the hemorrhagic diathesis, and that the immediate cause of death was a convulsion. The *London Lancet*, in commenting on his death, pays a graceful and becoming tribute to his lamented father the Prince Consort, whom he is said to have much resembled in features and in mind. He was much endeared to all classes of the people by his kindness of manner, generous sympathy, cultivated tastes and scholarly intelligence. His sudden demise on the threshold of a life rich in promise of future usefulness, when he was beginning to be loved and held in homage, not only for his illustrious rank, but also for his own natural good qualities, has cast a sad gloom over the entire nation, which will not soon be dispelled.

Books and Pamphlets.

DICTIONARY OF MEDICINE INCLUDING GENERAL PATHOLOGY, THERAPEUTICS, HYGIENE, AND THE DISEASES OF WOMEN AND CHILDREN by various authors, edited by Richard Quain, M.D., F.R.S. London, Eng. Fourth edition. New York: D. Appleton & Co.

We have been favored with a copy of this excellent work by the publishers, and have had much pleasure in looking over its contents. The work is already well and favorably known to many leading members of the profession. To those who have not been acquainted with former editions, we would say that it is a most useful and convenient work for reference at all times. The articles are written by some of the most eminent men in the profession, the list embracing such names as Adams, Aitken, Balfour, Bastian, Bennett, Bristowe, Broadbent, Brown Sequard, Brunton, Carpenter, Clarke, Curling, Cormack, Matthews Duncan, Farquharson, Fenwick, Ferrier, Fox, Gowers, Holmes, Hutchison, Jenner, Latham, Liveing, McKenzie, Murchison, Paget, Playfair, Roberts, Simon, Thompson, Thorowgood, Williams, Wilson, and a host of others of equal prominence. The diseases are taken up in alphabetical order and are fully discussed in regard to clinical history, pathology and treatment. The work is illustrated wherever illustrations can be of service in elucidation of the text. It is upon the whole a most valuable work, alike of interest to young and old, student and practitioner, and no medical library can be said to be complete without it.

THE CANADA EDUCATIONAL MONTHLY; Toronto: \$1.50 a year.

The April number of this standard independent magazine is to hand, and is replete with matter interesting alike to the professional and general reader. No school journal in America aims so high, or has such an able corps of regular contributors as *The Monthly*. The present number contains President Wilson's Inaugural Address on "Free Public Libraries;" Mr. Rye's paper on "University Life in the Early Part of the 17th Century;" Mr. Tattersall's on "Educational Theories and Theorists;" and Mr. Ward's on "The Duties of the Teacher." The University, Science and School Departments are full of interest to teachers and students. The Editorial Notes on

current educational questions are judicious and impartial, and indicate an intimate acquaintance with school affairs. The Educational Intelligence and Editor's Table are admirable features. We notice that the magazine is made the medium of official communication.

A TREATISE ON PHARMACY. By Edward Parrish. Fifth edition, enlarged and revised by Thomas S. Wiegand. Philadelphia: Henry C. Lea's Son & Co. Toronto: Williamson & Co.

In this excellent work for the student of Pharmacy will be found working formulæ for the use of the practical manipulator; comments upon the use and properties of the officinal preparations, processes for preparing and dispensing medicines; composition of chemical compounds—prominent properties and doses; modes of measuring, regulating, and applying heat for pharmaceutical purposes; on the art of selecting and combining medicines; pharmacy in its relation to organic chemistry; galenical and extemporaneous pharmacy. The student of Pharmacy will find in this volume a mine of information, brought up to the present standard of Chemical and Pharmaceutical Science.

THERAPEUTIC HANDBOOK OF THE U. S. PHARMACOPŒIA. By Robert T. Edes, A.B., M.D., Harvard. New York: Wm. Wood & Co. Toronto: Williamson & Co.

This book admirably fulfils a requirement for the student as a commentary on the U. S. Pharmacopœia, which is altogether too bulky a volume for anything but a work of reference. A succinct treatise therefore on drug action, physiological and therapeutic, dosage, incompatible substances, etc., is a great boon to the overworked pupil of the present day and cannot fail to be appreciated by him when the time for final examination approaches. The book is well printed and will be found a valuable addition to the works already published on the same subject.

A MANUAL OF OBSTETRICS. By A. F. A. King, M.D., Prof. of Obstetrics, Columbia University, Washington, with 59 illustrations. Second edition. Philadelphia: H. C. Lea's Son & Co.

It is only a short time since the issue of this work, and it must be very gratifying to the author to find such a rapid exhaustion of the first edition. The present edition has been revised and corrected, and such additions made as were necessary to bring

it fully up to the present knowledge of the subject. The work will be found useful to those for whom it is designed.

A PRACTICAL TREATISE ON SURGICAL DIAGNOSIS, for practitioners and students of medicine, by Ambrose L. Ranney, A.M. M.D., of New York. Third edition; revised, enlarged, and profusely illustrated. New York: William Wood & Co. Toronto: Hart & Co.

This work is designed as a manual of surgical diagnosis for students and practitioners of medicine, and as such will be found very serviceable for occasional reference. That it has been favorably received by the profession in the United States, may be inferred from the fact, that although a recent work, it has already reached the third edition. Much of the information given is in a tabulated form, and to some minds this is the readiest method of imparting instruction.

EPITOME OF SKIN DISEASES; with formulæ for students and practitioners; by Tilbury Fox, M.D. Third American edition. Philadelphia: H. C. Lea's, Son & Co. Toronto: Hart & Co.

The present edition of this well-known work has been edited by T. Colcott Fox, M.D., brother of the author. The classification of skin diseases adopted is the one promulgated by the American Dermatological Association. The style is clear and concise, the arrangement simple and convenient, and the work cannot fail to prove of great value to the student of dermatology.

A GUIDE TO AMERICAN MEDICAL STUDENTS IN EUROPE. By Henry Hun, M.D., Prof. of Nervous Diseases, Albany Medical College. New York: Wm. Wood & Co.

We have been much pleased with the perusal of this interesting little book. The author has been over the ground, and knows whereof he writes. The information supplied will be found of great practical value to all students and practitioners who intend visiting Europe to add to their store of medical knowledge.

THE STUDENTS HAND-BOOK OF FORENSIC MEDICINE AND MEDICAL POLICE, by H. Aubrey Husband, M.B.C.M., F.R.C.S.E., Lecturer on Medical Jurisprudence in the extra-academical school, Edinburgh. Fourth edition, revised. Edinburgh: E. & S. Livingstone.

The fourth edition of this admirable work has been thoroughly revised. New sections have been

added on criminal proceedings, somnambulism in its legal relations, and on the action of poisons, and many portions have been enlarged and rewritten, so that the work is now as complete a hand-book on this subject as is to be found in the English language. We have therefore great pleasure in recommending the work to our Canadian confrères, and especially as a convenient and reliable text-book for the use of medical students during their college course and in preparing for their examinations. The work is concise, clearly and well written, and embraces all phases of the subject usually treated of in similar works, and all within the compass of 600 pages duodecimo.

ILLUSTRATED MEDICINE AND SURGERY.—Vol II., No. IV., Oct., 1883. Edited by Drs. George Henry Fox and Fred. R. Sturges. New York: E. B. Treat & Co., 757 Broadway.

This work, which has been previously noticed in these columns, still keeps up its reputation for excellence in illustration and completeness of detail. The present number contains 21 illustrations. We commend the work to the attention of the profession in Canada.

VETERINARY MEDICINE AND SURGERY IN DISEASES AND INJURIES OF THE HORSE. By F. O. Kirby. Illustrated by four colored plates and one hundred and sixty-eight wood engravings. Cloth; 8vo.; pp. 326. Wm. Wood & Co., 1883. Toronto: Hart & Co.

In this work is presented in a concise and practical form, the diseases and injuries of the horse, and their appropriate treatment.

A POCKET AIDE-MEMOIRE, compiled specially for the instruction of the ambulance corps of the Dufferin Rifles of Canada. By William T. Harris, M.D., C.M., Surgeon Dufferin Rifles.

Births, Marriages and Deaths.

On the 10th of April, John F. Coad, M.R.C.S. Eng., of East Zorra, Ont., aged 72 years.

On the 4th of February, C. Deguise, M.D., of Quebec, aged — years.

On the 29th March, Dr. Wm. James, of Burgessville, in his 36th year.

On the 21st of March, P. N. Leclair, M.D. (McGill), of North Lancaster, Ont., aged 48 years.

THE CANADA LANCET.

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CRITICISM AND NEWS.

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Original Communications.

CASES OF POISONING BY CARBOLIC ACID—PARIS GREEN—BELLADONNA.*

BY J. C. MITCHELL, M.B., ENNISKILLEN, ONT.

It was my fortune to have the responsibility of three cases of poisoning devolve upon me within a year; and as such are comparatively rare, in the ordinary routine of a country practice, I thought a record of the symptoms actually observed, and the treatment used, might be interesting—if not instructive—to the members of this Association.

Case I.—Mrs. S., a widow lady, *æt.* 58 years, living three-fourths of a mile from my office, was on the 16th of November, 1881, preparing to retire for the night, at 10.30 p.m. She was troubled with rheumatism, and by mistake took a large dessert-spoonful of pure carbolie acid, instead of the remedy to which she usually resorted. She at once cried out, "I have taken the wrong medicine for it is burning my throat and my stomach dreadfully." Her daughter immediately discovered the mistake, and gave the alarm. I was speedily summoned to attend and was with the patient fifteen minutes after she had taken the acid. I found her in a partial stupor, talking somewhat deliriously, great muscular relaxation, weak thready pulse, cold clammy skin, pupils of eyes slightly contracted, breathing becoming of a stertorous character. The invasion of the symptoms had been very rapid. Previous to my arrival, the daughter had given an emetic of mustard without any effect. With some difficulty I aroused her sufficiently to drink four ounces of olive oil (all I had with me), when she recovered consciousness. I then prepared and administered an emetic of sulphate of zinc, which acted quickly and thoroughly; and soon left no doubt in our minds as

to the nature of the poison, as the atmosphere of the room was impregnated with the odor of carbolie acid. After the emesis had ceased, we gave her demulcent drinks, applied heat to the body, and had the satisfaction of leaving her in a couple of hours in a fair way to recovery. The posterior and central portion of tongue were hardened and corrugated by contact with the acid. The tongue and throat speedily healed; the stomach remained very irritable for a length of time.

Case II.—Mr. V., *æt.* 49 years, a respectable farmer living five miles from our village indulged frequently in the use of intoxicants. At 9 p.m. Sunday, September 3rd, 1882, when under the influence of liquor he mixed half a tea-cupful of the ordinary commercial Paris green—aceto-arsenite of copper—with water, and before any of the family were aware of his intention, swallowed the greater portion of the mixture. In an hour afterward I was with him. He was sensible, suffering very acutely at intervals from severe epigastric and abdominal pains, extreme pallor of countenance with anxious expression, cold clammy skin, feeble rapid pulse, made scarcely any complaint, in fact did not speak unless addressed. After each attack of pain he vomited freely, then complained of thirst. The vomited matter was bright green and there was considerable sediment of Paris green at the bottom of the vessel. The emesis began thirty minutes after taking the poison, partly no doubt from the action of an emetic of mustard his wife had induced him to take. Treatment consisted in giving good doses of dialyzed iron, large quantities of milk and eggs, keeping up free emesis until the green hue disappeared altogether. After that he became quite easy, but slightly stupid, pulse firmer, slower and skin warmer. Improvement lasted for more than an hour, when all the symptoms returned with much greater severity. His sufferings now were intense, great tenesmus, no diarrhoea, although bowels moved frequently, constant desire to void urine. He grew worse rapidly, and expired five hours after drinking the fatal potion.

Case III.—In each of the cases related, the kind of poison taken was known, in the one following, the toxic agent had to be decided from the symptoms manifested.

In the village of S—resided a Mr. T. and family, consisting of a wife and two daughters. Mr. T. was a delicate man, *æt.* 53 years, the elder

* Read at the Ontario Medical Association, June 6th, 1883.

daughter, æt. 26 years, a very delicate girl, having had several attacks of pneumonia; the younger, æt. 19 years, was in the enjoyment of very good health. On the evening of November 13th, 1882, the father and daughters were attending choir practice at a neighboring church, leaving their mother at home, who, in their absence, busied herself in preparing some herb-tea for all to partake of, as they were suffering from severe colds. The herbs were supposed to be only those they were constantly in the habit of using, viz., smartweed and mullin leaves. On returning home at 10 p.m., the father and daughters drank freely of the infusion, the mother only tasting it, as there was scarcely enough for all. The father went immediately to bed, the others remained up for a time. In a few moments all began to complain of dryness and burning sensation in the throat and mouth; soon the elder daughter grew dizzy, began laughing and acted like one intoxicated, then became delirious; the father and young girl complained of sickness, nausea, dizziness and strange feelings, and by the time the mother got a neighbor aroused and in the house, all were insensible.

I arrived at 11.30 p.m., found Mr. T. lying in bed in a state of coma, breathing very heavily, tongue extremely dry and swollen, unable to swallow, entirely unconscious, no sensation whatever, at intervals a convulsive movement passed over his frame. The sisters were in adjoining sitting-room, lying on beds hastily spread on the floor by the neighbors. Both were unconscious and swallowed with great difficulty anything given them. They retained some sensation. They had severe convulsions at intervals. In all three cases the countenances were of a dusky hue; the pupils of the eyes were dilated to the full; scarcely any of the iris could be distinguished, also strong external strabismus. From the marked mydriasis, together with the other symptoms present, it was evident the poison was one of the solanaceæ, and I was fully convinced that it was either belladonna or its alkaloid, an opinion, I think, pretty fully corroborated by the facts afterwards ascertained. The stupor exhibited by all the patients was most profound, in fact the whole nervous system was prostrated and paralyzed. Sharp emetics were given to the girls, but the elder one did not vomit as freely as her sister. I gave all the patients three $\frac{1}{2}$ gr. doses of morphia subcutaneously, at intervals of

an hour, and after the first injection the convulsions ceased, and after the third the effect on the pupil of the eye of the younger girl was quite perceptible. I also gave hypodermic injections of brandy.

A message had been dispatched for Dr. McLaughlin, of Bowmanville. On the Dr.'s arrival we used the stomach pump with all three, and after removing the contents of the stomach, we pumped in a strong infusion of green tea. In spite of all our efforts the elder sister grew gradually worse, the pulse became small, thready, and at 4 a.m. rose to 160. The younger girl had shown better symptoms all through, although at one time her pulse rose to 145, and the prognosis was very doubtful. At 5.30 a.m. when we attempted to pump in some warm milk and an infusion of tea, she struggled a good deal and finally roused up sufficiently to look around; we had her removed at once to her bedroom, and gave her a good potion of castor oil. The other poor girl died at 6 a.m., having never rallied in the slightest from the time she first became unconscious. Continued giving the father strong tea, warm milk, brandy and aromatic spirits of ammonia, by means of stomach pump. It was necessary to hold his tongue protruded from his mouth all the time to enable him to breathe at all easily. His pulse varied from 130 to 170. At noon he rallied a little, opened his eyes, looked around and resisted slightly when we were using the pump. The drug, however, had done its work with an enfeebled constitution. In the afternoon he sank gradually and died at 4 p.m., eighteen hours after partaking of his herb tea. The remaining daughter slowly recovered, but was very ill for three weeks. The tongue, throat and fauces were swollen to such an extent that but little could be swallowed for a day or so. There was complete aphonia for a time; harsh, dry cough, with considerable bronchial irritation. Quite a scarlatinal rash over a greater portion of the skin, which lasted two or three days. For two weeks the temperature of the body ranged from 101° to 103° Fahr., and the pulse from 110 to 125. Treated symptoms as they arose, and the patient finally made a good recovery.

I may state here that Dr. McLaughlin fully concurred in my opinion as to the character of the poison. In examining the remaining herbs not

used for the infusion, we could find no trace of any poisonous plant, and that from which they drank the tea had been boiled too much to distinguish the various herbs. There was a peculiar narcotic odor very perceptible from the boiled herbs, the contents of the stomach, and also from the urine—withdrawn by catheter—very similar to the odor of the tincture of belladonna, with which we compared it. Mrs. T.—stated that the herbs had been gathered by the deceased husband. That he did this work in a very careless manner, just plucking them in handfuls as they happened. She also informed me that a large weed grew in the garden bearing a round berry of a purplish hue when ripe. I found, on enquiry, that large quantities of this weed grew in the neighborhood, and from its description have no doubt that it is the *atropa belladonna*, or deadly nightshade. That the plant must be very rich in its active principle *atropia* is evidenced by this case, as it is not likely that more than one stalk and its leaves were in the infusion, as any larger quantity would have been observed in the small amount used.

In the fatal cases putrefaction commenced very soon after death, and the bodies were covered with livid spots. There was also a bloody discharge from nose and mouth. The smell was very peculiar and offensive. The bodies were interred the day after death, and the features were so much discolored that the caskets were kept closed at the funeral.

Very much has been written as to the antagonism of belladonna and opium, since Prosper Alpin, in 1570, first observed that the action of the latter drug was greatly enfeebled when given in combination. Dr. Anderson read a paper in Edinburgh in 1854, showing that these drugs were antagonistic in their action upon the system. Trousseau, in his "Treatise on Therapeutics," also makes this a strong point. He says :

"Angelo Poma, Cazin, Benjamin Bell, Béhier, Lee, McNamara, Seaton, Frelenmeyer, Onsum, Bathurst Woodman, and Fournüller, all give cases of belladonna poisoning cured by opium. In these cases it is remarkable that persons poisoned by belladonna have been able to take enormous doses of opium without showing the symptoms of intoxication from opium." According to M. Béhier the quantity of opium required to combat the intoxication of belladonna ought to be greater than that

of the belladonna taken. In the case of the girl that recovered, although I gave her $1\frac{1}{2}$ grs. of morphia hypodermically in two hours, she regained consciousness in four or five hours after, and exhibited none of the usual symptoms expected from large doses of that drug.

PARACENTESIS OF THE PERICARDIUM.*

BY J. W. MACDONALD, M.D., L.R.C.S.E.,

Medical Officer, Steel Co. of Canada, Londonderry, N.S.

I was first called to see the patient, a married woman, aged 30, on the evening of June 10th, 1883. She stated that, three weeks previously, she had been seized with severe pains in the joints, attended with high fever. A day or two afterwards, she complained of pain and violent beating at the heart.

Condition on June 10th. She was unable to lie down with comfort; the face was pale, anxious, and slightly cedematous; the breathing was short and panting; the heart's action tumultuous, and its movements could be perceived through her clothing. On examination of the chest, a dull area was found over the præcordial region, extending from the right edge of the sternum towards the left for about eight inches, and from the seventh intercostal space to the level of the upper margin of the second rib. A loud distinct to-and-fro murmur at the apex, and a harsh systolic murmur at the base, were the sounds heard on auscultation. The lower lobe of the left lung, posteriorly, was very dull on percussion, and conducted the heart-sounds, so that the murmurs could be very distinctly heard in this situation. Over this area, there was also puerile respiration and increased vocal resonance. A narrow strip, giving normal sounds on percussion, extended down the side from the axilla, and divided the dull areas in the front and back of the left chest. The pulse was small, irregular, and 120 per minute. She was troubled with diarrhœa.

Blisters, iodine, and diuretics were employed, and for a few days the fluid diminished; but the symptoms became aggravated, and the dyspnœa and agony about the heart became unbearable. To use the patient's own words, she felt "as if the heart was going to burst." She could get no rest except when propped upright, and she frequently

fainted. The diarrhoea continued, and, in the hope that it might promote absorption of the effusion, I made no attempt to check it.

June 18th. I resolved to operate, and was assisted by Dr. Sutherland. To decide upon a suitable situation for the opening was a great difficulty. The point generally adopted, and first recommended by Dieulafoy—viz., in the fifth intercostal space and one inch to the left of the sternum—was in this case unsuitable; for in that situation the heart-impulse could be most strongly felt. No part appeared more prominent than another, and the difficulty was further increased from the fact that the patient was nursing her child, and the breasts were consequently large. A point, one inch below the nipple, and close to the lower margin of dullness, was at length fixed upon; first, because no heart-impulse could be felt there; and, secondly, because it was at the most dependent part of the pericardial cavity. The patient was placed in a semi-recumbent position; chloroform was very cautiously given, and the mamma was held up out of the way. I then made a preliminary incision through the skin, and dissected down carefully between the ribs. No impulse being felt by the finger in the wound, I pushed a moderate-sized aspirating-needle through the remaining tissues; and, feeling that I had entered the cavity, withdrew the stilette. A few drops of greenish-looking fluid escaped; but it appeared impossible to get it to run freely, even after applying the aspirator. Just as I was preparing to enlarge the opening, for the purpose of introducing a tube, the fluid began to run freely; and, on the patient drawing a full breath, it escaped in little jets. After persevering for some time, the cavity was emptied; the dull area over the heart was reduced to its normal size, and the patient, though extremely weak and inclined to faint, was very greatly relieved. The fluid withdrawn measured thirty-two ounces; was of a greenish colour, resembling bile, and tended to coagulate on cooling. Shortly after the operation, she could lie down with comfort on either side, and draw a deep breath without inconvenience. The pulse fell to 100, and became more firm and regular.

June 19th. She had had a comfortable night, and felt very much better. The dullness over the lower lobe of the left lung had become less, and

the respiratory murmur was returning to its natural character.

June 25th. Diarrhoea, which had for some time been a prominent symptom, had stopped. The area of heart-dullness was evidently increasing, and with it the other symptoms, which indicated an accumulation of the fluid. Iodine was applied over the præcordia, and a pill containing one-sixth of a grain of elaterium given at night.

June 27th. The elaterium produced copious watery discharges, which were followed by a marked diminution of the area of dullness, and a great improvement in the breathing.

June 30th. Her condition had so much improved as to permit her going to her home in St. John. Up to the present time (August 30th), she has continued to improve. She can walk more than half-a-mile without inconvenience, and has gained strength. Dr. Bayard, of St. John, who kindly examined her a few days ago, states that the fluid has not returned, but the endocardial murmur is still to be heard.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—One would imagine from the summary manner in which Dr. Rogers was compelled to produce his credentials that the Medical Board of New Brunswick would surely keep an eye on anyone attempting to practice in the Province without the necessary qualifications as set forth in the new Medical Act. Such is not the case, however. A gentleman from P. E. Island, who studied and graduated in Bowdoin College, Maine, U. S., is now practicing in the vicinity of Cape Tormentine. The Act specifies that no American graduate, as such, can practice until he shall have passed a successful examination before the Provincial Medical Board. It further sets forth, that any one attempting to practice without complying with said law shall be prosecuted, fined, &c. &c. Now, this gentleman is a graduate of a second-rate College, and he has not passed any examination before the Board as the Act specifies. How is this? Has he, the possessor of an illegal qualification, been allowed to register on the same terms as a graduate of Edinburgh, McGill, or Trinity? Surely not! But, if so, there must be favouritism and corrup-

tion somewhere. If he has not registered according to law, why is he allowed to set the statutes of the province at defiance, and to be an insult and a reproach to the thoroughly educated graduates of British and Dominion Institutions. Will Dr. Atherton, Dr. Currie, or some other member of the Registration Committee rise and explain!

Yours truly,

TORONTONENSIS.

To the Editor of the CANADA LANCET.

SIR,—I regret to observe an article in the last issue of the other medical Journal published in Toronto, which contains a most wanton attack on one of the Edinburgh Medical Colleges. As a member of one of these Colleges (probably the one referred to, as the writer does not specify), I feel that the honor and fair name of *alma mater* is being outraged by parties who are either ignorantly or wilfully lending their small influence to libel time-honored institutions. I trust, sir, that you will not allow the foul libel to pass unrefuted.

Yours sincerely,

May 15th, '84.

ALPHA.

[We have read the article referred to in our contemporary and our reply will be found in another column.—Ed. LANCET.]

Selected Articles.

ON DISLOCATIONS AND FRACTURES.

The following is an abstract of a lecture delivered at the London Hospital, February 15, 1884, by Jonathan Hutchinson, F.R.C.S., *Med. Press*.

Mr. Hutchinson announced his intention in this lecture, of dealing, in the way of rapid survey, with the general principles involved in the recognition and treatment of dislocations and fractures; and of the first kind of injuries he especially insisted on the great importance attaching to their diagnosis by the practitioner. By the commission of errors in this respect, and by failing to appreciate the true nature of an injury involving dislocation of a limb, the surgeon is not unlikely to secure for himself a greater amount of discredit than would follow almost any mistake he could make in professional practice. Nor is it difficult to understand the reason for this, since by the permitted existence of dislocation for any considerable length of

time, deformities may be set up, and discomfort to the patient thereby produced, which no attempt to cure will succeed in removing; but, as a general rule, all such consequences arise from the carelessness of the practitioner, who never ought, unless guilty of insufficient or incautious examination, to overlook any ordinary case of dislocation. In order, however, to prevent this untoward occurrence, it is well to bear in mind, and to call into use on every occasion, the fact that a dislocation comes under treatment of two safe rules, as follows:

1. Never examine a patient under these circumstances without stripping him and making accurate comparison of the two sides of the body, and

2. Should any doubt arise as to the existence of a dislocation after cursory examination, conducted according to Rule 1, then refuse to be satisfied until the patient has been put under the influence of an anæsthetic, and while in this condition subjected to every available test, with a view to absolute accuracy of diagnosis. Especially should this precaution be observed in the case of young patients, who naturally resist manipulation when awake, and with those who are unusually sensitive and restive under examination.

In many cases it will occur that instead of being simple, a dislocation will be complicated by the co-existence of a fracture along with it, whereby the difficulty connected with its diagnosis will be much increased, and in young children particularly, complications of this character are very frequently met with, dislocations of a simple nature being rare among them. In his own experience, Mr. Hutchinson declared he had never met with a simple dislocation of the shoulder joint in a child, but, on the other hand, he had seen numbers in which there had been separation of the upper epiphysis of the humerus, with consequent simulation of dislocation. In the wrist this form of injury does not occur, the hip being by far the most usual site of it, and in the case of children it is important to remember that when symptoms of dislocation are apparent they should be taken as affording indication of the occurrence of other injuries as well.

Among young children separation of the epiphysis of the long bones is a common accident, and it is not to be in any way regarded as a fracture either of the anatomical or surgical neck. In consequence of the force required to produce complete displacement of the sundered parts being very great, this condition is, as a rule, replaced by one of incomplete displacement, which also the extensive surfaces of the disconnected portions of bone contribute to bring about—in the humerus, *e. g.*—in which, when so injured, a forward sliding of the bone takes place for a little distance, but the combination of this separation of the epiphysis and dislocation of the bone at the joint is one of those accidents which, in Mr. Hutchinson's experience, do not occur.

Special risks of danger, even to a fatal termination of the case, attend those examples of separation of the epiphysis in which irregular stripping away of the periosteum from the shaft of the bone occurs, the epiphyseal end adhering, and a periosteal sleeve, with muscular attachments being loosened from the subjacent bone. Museum specimens of this kind of injury are rare, notwithstanding they are not infrequent, but when produced they rapidly end in death. Suppuration, too, which in fractures of bone rarely occurs, may attend the separation of epiphyses, being in such case due to the separation of the periosteum.

In adults dislocation of both bones of the forearm at the elbow joint is not uncommon, but among children it is exceedingly so; in this class of patients that form of injury which is described as a dislocation of such nature consists in the clean separation of the epiphyses, which is encouraged in the elbow-joint by the profusion of ossifying centres found in that region, and which, when it is seen, is usually said to be a dislocation backwards. The amount of displacement produced by such an accident depends on the position assumed by the bones affected in relation to the joint, and the possibility of the confusing appearances that may be seen ought to be an effectual guard against the issue of a hasty or unwarranted utterance respecting the absence of any fracture. The ease with which the displacement of the epiphyses can take place in children is the main reason why so-called dislocations of the elbow joint are so commonly seen in them, and the factor is found in the low position of the coronoid process, the principal opponent to backward dislocation in young subjects. This process is, indeed, practically an epiphysis itself at this age, being of soft, yielding structure, and being easily broken down.

In treatment of separation of the epiphysis at the elbow in children, the plan most successfully practiced is that of fixation on a moulded splint adjusted to the back of the limb, which is to be bent into a position in which the forearm is at right angles to the upper part of the limb. The splint is to extend high up the arm, and in fastening it strapping should be employed, a pad being so adjusted as to bring steady pressure on the upper part of the humerus. All the steps of the operation should be carried on while the patient is completely under the influence of an anæsthetic, the free and invariable use of which was strongly advocated by the lecturer in these cases. The pressure, moreover, thus applied to the lower end of the humerus, must be considerable in order to secure the desired result, and should not be omitted on account of the swelling which in some cases will be found present to some extent, being occasioned by the tearing injury inflicted on the periosteum. In a recent case seen by Mr. Hutchinson, neglect of these precautionary details had resulted in ankylosis of the

joint, and it is desirable that the practitioner should always be guarded in his prognosis of a recovery without stiffness of the elbow in all such cases. In separation of the lower epiphysis of the radius, it is common for a mistaken diagnosis to be made, the injury under such circumstances being assigned as dislocation of the wrist joint. One of the best examples of the condition so produced is to be found in a preparation in the London Hospital Museum, and it is highly important to recognize the nature of the lesion whenever it occurs. As a rule, there is only an incomplete displacement of the epiphysis, but one case at least is on record in which the part was entirely separated. The disunited parts should be placed in apposition, under an anæsthetic, as a first step toward treatment, and then the limb should be put up in the ordinary way.

In proof of the infrequent occurrence of dislocation of the wrist, Mr. Hutchinson said he had never seen a case himself, and those injuries which were described as such dislocations invariably turned out to be, in the young, separation of the epiphysis, and in the adult, fracture. Likewise he questioned the existence of the so-called subglenoid dislocation at the shoulder, and in every case he had examined with a view to testing the existence of such a deformity he found it to be one of subcoracoid dislocation, the certainty of which can be made clear by resort to accurate measurement, by which means the absence of any lengthening of the limb, a condition which must necessarily occur to the extent of one and a half or two inches in subglenoid dislocation, is at once rendered apparent. To Professor Flower is due the credit of drawing attention to the facts here explained, and which imply that what has been called subglenoid is in reality subcoracoid dislocation. Dr. Howe had also, previously to Flower's observations, noticed that lengthening must necessarily follow on subglenoid dislocation, but in spite of all the correction the error received, a well-known manual of surgery continues in its latest edition to perpetuate it, and by means of illustrations depicts the two forms of displacement, showing the limbs as being of equal length in both forms of injury.

Among children, displacements of the elbow may be treated with very favorable prospects of obtaining good results, but the case is very different when the patient is advanced in years, for although in them reduction may be completely effected without fracture, still there is ever present danger of subsequent development of chronic rheumatic arthritis in the joint, this being an almost invariable sequel in such cases. Different opinions, however, have been expressed respecting the order in which the two events occur, whether, that is, the dislocation is primary, but the lecturer decidedly averred that there can be no question that such is the fact. In

consequence, therefore, of the extreme probability of future occurrence of rheumatic arthritis in the majority of elderly patients who come under treatment for displaced elbow, it is incumbent upon the surgeon to speak with the greatest caution when called upon to give promise of a useful limb, the chances of any result of this kind being very small in comparison with the almost certain probability of permanent arthritic mischief setting in.

Fractures are grouped under two heads, viz. :

A. Fractures with displacement.

B. Fractures without displacement.

In connection with these injuries it must be remembered that, though occurring in the same bone, and bearing the same distinctive name, *e. g.*, Potts' or Colles' fractures, still a very great amount of diversity may be exhibited by them, and it must not be expected that any two examples of the same variety of fracture will be exactly similar in all respects.

As in cases of separation of epiphysis, so in fractures, the nearer the injury is to the joint extremity of the bone, the greater probability there will be that displacement of the fragments will only partially ensue. Impaction of the pieces may occur, and as a result it often happens that the favorable position assumed on recovery is due, not to the surgeon's skilful treatment, but to the accidental fixation of the fragments of bone at the time when the injury has been received. For this reason it is advisable to avoid hurry in placing retentive apparatus around the limb under such circumstances, for it is quite possible to set up a great deal of harm by the injudicious application of pressure in this way. In his own practice, Mr. Hutchinson said he had often treated Colles' fracture of the wrist without employing any kind of splint whatever, and he urged the necessity of carefully considering the needs of each case separately, and then to treat it in accordance with the requirements it possesses.

In the majority of cases of Colles's fractures but a small amount of displacement is found to exist, but exceptional instances do occur in which the reverse condition obtains, and such cases present difficulties in the way of treatment. Some years ago Mr. Hutchinson dissected many examples of this form of fracture, and he had come across none in which any great amount of displacement existed, and in some cases, though crepitus could be felt, it was not until the periosteum was removed that actual evidence of displacement could be obtained.

Complete reduction is imperatively requisite when displacement accompanies fracture ; and in all such cases it is very much wiser to bring the patient under the influence of an anæsthetic before commencing to restore its contour to the distorted limb. This proceeding is the more desirable also on account of the absolute safety with which anæsthetics can now be administered ; and aided by

this means of assistance, the surgeon should not rest contented until his efforts are rewarded by perfect restoration of its lost symmetry to the injured parts, except, of course, in cases where an extreme degree of impaction renders any such occurrence impossible.

Once the fragments have been restored to their proper place, however, there is no tendency in them to resume the vicious position assumed as a result of fracture ; and hence necessity for confining the limb in a splint apparatus will not exist. This method of treatment will be demanded in a certain number of instances, being those which form exceptions to the general rule just laid down ; but Mr. Hutchinson considers that quite 4-5ths of the fractures of limbs can be most satisfactorily treated without applying any splint whatever, the harm caused by which through pressure far exceeds the benefit conferred. Whenever they are employed, the simpler the kind of splint that is used the better will be the result, the straight form being the best possible, admitting of free extension, and being also easily retained in place. Fourteen days should, Mr. Hutchinson urged, be the maximum time during which, if it must be applied, a splint should be allowed to remain, as otherwise there arises much danger of rheumatic stiffening of the joint.

As a commentary on the futility of inventing complicated splints and apparatus for fixing fractured limbs, none of which have ever received general approval, the lecturer referred to an ingenious instrument devised by Dr. Gordon, of Belfast, after long-continued anatomical study of Colles' fractures. This, which was intended for general use among surgeons, is figured, said Mr. Hutchinson, in a text-book by a leading surgeon, *upside down* ; and assuming from this that even the author of the work is practically unacquainted with the splint, although he writes about it, what chance is there of its ever being universally adopted ?

Not only Colles', but all fractures, are most successfully treated by extension, which can readily be made through the agency of the simple straight splint. Very thick pads should be fitted to the splint, and in ordering from instrument makers it is necessary to insist on this especially, particularly with regard to splints for treatment of fractured femur. Finally, on this subject of splints, Mr. Hutchinson declared that he had seen many more instances of bad union follow the use of modern improved apparatus than ever were witnessed under the old plan of fractures by the straight splint.

Fractures of the neck of the femur occur in a great variety of forms, and it is an unfortunate conventionality which divides them into extra and into intra-capsular fractures as though the bone was always broken straight across either in or outside the capsule of the joint. As a matter of fact, examination of numerous specimens showed this to

be an occurrence of great rarity, and the varieties assumed are very considerable. Thus the great trochanter may be broken across, or both trochanters, and the fracture itself may be partly without the capsule. When great deformity exists, however, the existence of extra-capsular fracture may be suspected, and on grasping both hips if there is found greater thickness on the injured side it may be taken as certain that the fracture is at any rate not entirely in the capsule. In all cases of this class of fracture, whether so called extra or intra-capsular, union by bone should be the surgeon's principal aim; and such a result may, in Mr. Hutchinson's opinion, be expected.

GASTROSTOMY FOR CARCINOMATOUS STRICTURE OF THE ŒSOPHAGUS.

BY PROF. S. W. GROSS, PHILADELPHIA

The first case is a woman, fifty-one years of age, with stricture of the œsophagus, depending on carcinoma, whom you saw five weeks ago. As I found it impossible to pass a bougie, or a soft tube for the purpose of alimentation, and as the trouble in swallowing grew worse and worse, I was finally compelled to open the stomach. Four weeks ago I made an incision parallel with and three-fourths of an inch below the eighth and ninth costal cartilages, down to the peritoneum. The bleeding having been arrested, I then opened the abdominal cavity, and attached the parietal peritoneum to the wall of the stomach with a continued suture of fine black silk, and I also stitched the wall of the stomach to the wall of the abdomen with an outer row of interrupted sutures, so as to afford as much surface as possible for adhesion between the two surfaces of the peritoneum. In this connection, I must say to you that when you insert sutures in the stomach or intestines, you should be careful that they do not penetrate the entire thickness of the viscera. The serous and muscular coats alone should be included, so that the little openings will not admit of the escape of the contents of the organ, through which peritonitis will ensue.

For a few days after the operation the patient was fed by the rectum. Afterward, when the spasm of the œsophagus did not prevent it, she received by the mouth dry champagne, milk, eggs, and chicken soup. At times the spasm was so great that for eighteen or twenty hours she was unable to swallow anything, when we had to return to rectal alimentation. To every three ounces of food given by enema, we added a teaspoonful of the liquor pancreaticus, one-fourth of a grain of carbolic acid and four grains of bicarbonate of sodium. In this way we not only promoted rectal digestion, which is an alkaline digestion, but also prevented the occurrence of tympanites, which was a troublesome symptom for a few days.

Last Thursday, or three weeks after the operation, I made a very small puncture into the stomach and inserted an elastic tube. I bring the patient before you to-day to show you a successful issue after the operation of gastrostomy, which means making a mouth or opening in the stomach for the purpose of nutrition. The incision in the stomach should be small, since with a large opening not only would there be a tendency for the contents of the stomach to escape, making the condition of the patient a dirty one, but the gastric juice would produce troublesome and painful inflammation around the margin of the wound.

I will now show you how the patient receives her food. This gum tube, which is cut off at the point, like the point of a pen, in order to facilitate its introduction, and which equals No. 15 of the French catheter scale, or has a diameter of about three-sixteenths of an inch, is passed into the stomach. To the proximate end of the tube a small glass funnel is attached, into which the warm nourishment is poured. In this way we have provided against death from starvation. There is no necessity for leaving the tube in the stomach, as it can be introduced whenever we desire to feed the patient although for the first few days it was retained, to prevent the closure of the opening.

There are probably a good many persons—we cannot account for tastes—who would rather die than submit to an operation of this description. On the other hand, there are others who prefer to live as long as they possibly can, so that in cases where death is threatened by starvation, gastrostomy may be performed if the patient desires it. The risks of the operation are almost nothing. We have thrown off the old superstitions in regard to the peritoneum. At the present day, after operations involving this membrane, we do not expect the patient to die from peritonitis. The trouble with gastrostomy is, that in the majority of cases the operation has been postponed too long; the patients are run down and unable to rally.

In cases of cicatricial stricture of the œsophagus, resulting from swallowing irritating fluids, as solutions of lye, or strong acids, it is found that the œsophagus becomes very much dilated above the point of stricture, so that we may speak of a complementary stomach in that situation. In cases of this kind, as well as in cases of the one before you, the patient can really enjoy food, which, after having been chewed and swallowed, may be retained in this receptacle for a little while, when it can be regurgitated into a tube, one end of which is in the stomach and the other in the mouth. Dr. Herff, of San Antonio, Texas, informs me that he has under his care a child which has been nourished in this way for four years and a half.

HYDROFULE, RADICAL CURE.

I propose, to-day, to show you the treatment by

injection of carbolic acid. This plan originated with a physician of Tennessee, whose name I do not recall, some ten years ago, and it has been popularized by Dr. Levis, of this city. The method of applying the carbolic acid is as follows: The fluid having been drawn off with a trocar, one drachm of the acid, rendered fluid by the addition of a minute quantity of water or glycerine, is injected into the sac by means of a rubber syringe provided with a nozzle long enough to reach through the canula. The canula and syringe are then removed, and the scrotum manipulated so as to bring the agent in contact with every portion of the serous surface. There is, at first, a little pain, but this is soon followed by numbness or anaesthesia. The patient may walk around for twenty-four hours, but he must then keep to his bed, with the scrotum supported by a proper bandage. This plan is said to be very efficient, and not liable to be followed by relapse. Dr. Levis, who has had a large experience with it, records an almost uniform, if not an entire success. Other surgeons have not met with equally good results. In a case which I treated in this hospital some time ago, the injection of carbolic acid was followed by a large effusion of blood into the sac of the tunica vaginalis, which resulted from the erosion of the serous membrane and the loss of support of the underlying vessels. The blood was evacuated and the patient recovered. I have not done the operation very often, but I have met with this complication on two occasions.

Before introducing the trocar, it should be mentioned that the scrotum is to be smeared with cosmoline, so that if any of the carbolic acid should fall upon the skin it will not produce excoriation.

INTERNAL HEMORRHOIDS—LIGATION.

This man, twenty-seven years of age, has had for many years, more or less pain in the back, which has become much aggravated during the past week. For the past four months he has had hemorrhage every time the bowels have been moved, and at the same time there was a protrusion of a tumor, about as large as a grape, from the anus. The operation which I shall show you is that of ligation. The bowels should be moved by an enema, and just before the operation the patient sits over a bucket of boiling water. The steam relaxes the part and a little straining brings the pile into view. As the man strains, you can see two tumors protrude. Around the small one it will be sufficient to place a ligature, but I shall transfix the larger tumor with a needle armed with a double ligature, and tie it in two sections. When there are a number of piles, say six or seven, it is not necessary to operate on all. If four are tied, the object will be accomplished; the amount of inflammation set up being sufficient to obliterate all. You should never allow a patient to walk about after any operation

for hemorrhoids, no matter whether it is a simple one, as in the present instance, or a more severe one, as clamping the tumors, cutting them off, and searing the cut surface with the hot iron. The patient must go to bed, so as to run as little risk from pyæmia and tetanus as possible.

In your books you will find it stated that a certain amount of laudanum should be thrown into the bowel, or an opium suppository be used after the operation. I consider this a bad practice. The rectum is already stuffed up enough. If the patient suffers pain, one-third of a grain of morphia may be given hypodermatically. The bowels should be confined for three or four days, or until the patient begins to feel a little uneasy about the belly, when a free and easy motion may be secured by injecting six ounces of sweet oil, and following it up the next morning with half an ounce of castor-oil, by the mouth. After all operations upon the bowel, you should inquire into the condition of the bladder, since there is reflex spasm of the bladder, causing retention of the urine, which will have to be relieved with the catheter.—*Col. and Clin. Record.*

PLASTER OF PARIS IN FRACTURE OF THE PATELLA.

Dr. Little, of New York, (*N. Y. Med. Journal*), describes his method of treating fractures of the patella as follows:—It will, perhaps, be best for me to state at the outset, in order to avoid a misunderstanding, that I always make a distinction between the plaster-of-Paris *bandage* and the plaster-of-Paris *splint*; two entirely different methods of using this material. The method which I propose to describe is by the use of the plaster-of-Paris splint, which was first introduced by me in 1861, and first applied to a fracture of the patella, in 1863, in a patient of Dr. Tucker, of this city, and which I have used in all the cases that have come under my care in St. Luke's and St. Vincent's Hospitals, as well as in my private practice.

Immediately after the receipt of the injury, I elevate the limb slightly, and place it on a pillow, or a single inclined plane, and wait until the swelling and inflammatory action which follow have subsided. The limb is placed in this position simply for the comfort of the patient, and not for the purpose of relaxing the quadriceps extensor muscle, and thus preventing the separation of the fragments, which was formerly considered necessary. Although I have often attempted, I have never been able, to demonstrate that it made any appreciable difference in regard to the separation of the fragments whether the limb was in a straight position or the thigh flexed on the pelvis. Sometimes, when the effusion into the synovial cavity is great, I apply pressure as soon as the patient is able to bear it, by means of a bandage. When

the swelling has subsided, which takes place from five days to a week, the following dressing is applied: A posterior splint is made of two thicknesses of bleached Canton flannel, strengthened in the middle, under the knee, by two extra layers; this is made long enough to reach from a little above the ankle to above the middle of the thigh, and wide enough to cover two-thirds of the circumference of the limb above and below the joint, but at the joint it should only just cover the condyles of the femur. Two pieces of Canton flannel, of from two and a half to three inches in width, double thickness, one long enough nearly to encircle the limb at the ankle, the other to encircle it at the upper third of the thigh, are prepared at the same time. The pieces designed for the posterior splint are then thoroughly saturated in a mixture of plaster-of-Paris and water, taking care that the mixture is not too thick, and then smoothed out upon a board with the hand, and applied smoothly to the limb. Then the two bands are prepared in the same way and applied around the upper and lower extremities to hold it in position. A dry roller bandage is then firmly applied over all, and the plaster allowed to set.

As soon as this is accomplished the bandage is removed, and we have a firm posterior splint, secured above and below by transverse bands. Two other strips, of a double thickness of Canton flannel an inch wide, and long enough to overlap on the posterior surface of the splint, are saturated in a fresh mixture of plaster-of-Paris and then tightly applied above and below the patella, while the fragments are held in position by an assistant, in the same manner as adhesive straps are used for coaptation in this fracture. A dry roller bandage is then rapidly applied with the figure-of-eight turns over the strips. The surgeon then, with thumb and finger of each hand over these coaptation bands, forces the fragments into close approximation, and holds them there until the plaster has set (Fig. 1). The bandage is then removed and a fresh one applied over the whole length of the limb. The dressing is then complete. Fig. 2 shows the splint with the bandage removed. It is a good plan for the surgeon, before applying the coaptation bands, to see that the fragments can be easily approximated. In a number of cases I have found some difficulty in keeping the fragments in the same plane, or in preventing them from tilting, there being a tendency for one to rise above the other. This can be overcome by making pressure with the fingers over the line of fracture while waiting for the bands to harden.

This dressing differs essentially from all others, in that the fragments are adjusted by the hands of the surgeon, and the "setting" of the plaster keeps them in the exact position in which they were held. The patient is not compelled to keep his bed, but may sit up or go about on crutches with but little

inconvenience. This apparatus, like all plaster-of-Paris splints, should be applied directly against the skin, care being taken, however, to remove the hair, or else smear the limb with cosmoline or oil.

The condition of the fragments can now be examined at any time by simply removing the bandage, and in case any separation has taken place in consequence of the shrinkage of the limb, it can be corrected by removing the coaptation bands and applying new ones. Care should be taken, if this becomes necessary, which is seldom the case, to moisten the posterior splint in order to insure the adherence of the new pieces.

Pressure sores have never been produced in my experience, nor have the patients ever complained of any pain caused by undue tightness of the dress-

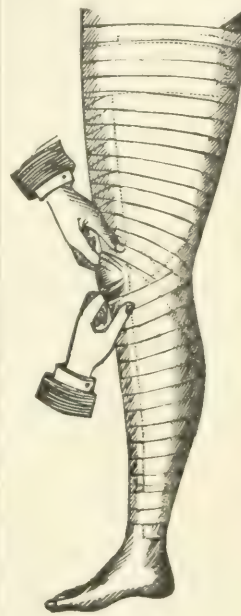


FIG. 1.

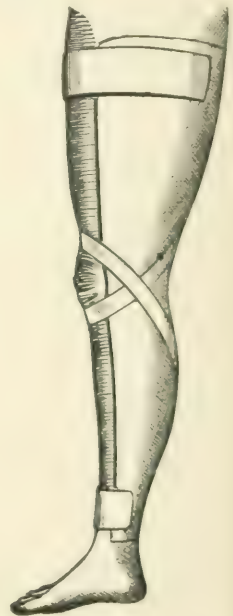


FIG. 2.

ing. In fact, constriction of the limb by the splint, bands, or bandages, so as to interfere with the circulation, cannot occur, even in inexperienced hands. In order to prevent a rough edge at the upper and lower extremities of the splint, it is advisable to fold them over about half an inch, thus bringing a perfectly smooth edge in contact with the soft parts. This dressing should be left on for from six to eight weeks. The majority of patients rarely have any appreciable separation of the fragments at the end of the treatment, but as the union is generally ligamentous, a certain amount of separation will take place in time, as in all cases in which there is not bony union.

A case that I treated ten years ago, by this method, came under my notice again a few weeks since; the fragments, which after the treatment were

almost in direct contact, I found had separated only a little more than half an inch. Two cases treated by this apparatus, at St. Vincent's Hospital, resulted in bony union.

PUNCTURED WOUNDS OF THE SKULL.

In a recent discussion on this subject, before the Academy of Medicine of Cincinnati, Ohio, reported in *The Cincinnati Lancet and Clinic*, Jan. 5th, 1884, Dr. P. S. Conner (Class of 1861), in introducing the subject for discussion, said he was well aware that it might be looked upon by many as rather trite, and yet the gravity of these sometimes apparently slight injuries renders it of great importance. The treatment of simple punctured wounds of the cranium is still a matter of discussion, from the fact that it is frequently difficult to decide whether the injury received is one of the skull alone, or whether the structures underneath, the brain and its coverings, are also involved. If the injury be of a definite character, the question arises whether we are justified in interfering actively in order to prevent the development of dangerous complications, or whether it is more prudent to wait until further symptoms arise. As regards active interference, we have the advocates of the extreme use of the trephine from Ambrose Paré to Pott, and the expounders of the doctrine, as Stromeyer, that the trephine ought not to be used in any case. Stromeyer claims that, although the injury inflicted may be of the utmost gravity, the trephining of the skull will but increase the dangerous symptoms.

The speaker alluded not to the general fractures of the skull, but to the punctured form. No one would fail to recognize an injury where the skull is driven in, but in a punctured wound the gravity is often overlooked; and yet, without any apparently severe injury externally, such an injury may perhaps prove most dangerous.

The skull may be punctured by the blade of a knife, a bullet, a piece of glass, a sharp instrument, as a pick, and various other substances. The depth of penetration may be out of all proportion to the extent laterally, and the symptoms may be masked for hours or days. The injury is probably greater to the internal than the external table of the skull, or a diploic injury may be followed by inflammation of the veins or pyemia, but usually the internal table is broken off and the meninges or the encephalic vessels are pierced. Hemorrhage and inflammation may thus result, and sometimes the brain substance itself may be injured, the penetration extending perhaps even to the opening of the lateral ventricles. With all these serious consequences a diagnosis is frequently not made.

The speaker remembered one instance where

death resulted in forty-eight hours, and the wound in the skull had been overlooked altogether. Knowing the liability of suppurative of wounds of the external and internal tables of the skull, we can understand the necessity for drainage so that a steady outflow is necessary for the safety of the individual. Death is often to be attributed to a punctured fracture of the skull, and it is therefore desirable to call attention to the danger of injuries about the head, even if they are scalp wounds, to decide whether the trephine should be used or not.

The speaker could not see where the danger lies *per se* in the use of the trephine; it is not followed by a great mortality, and the latest examinations made by Walshman, of London, shows that there is but little danger. The trephine simply converts a wound with a ragged edge into a smooth one, and the removal of a button of bone frequently prevents inflammation of the meninges, or a localized inflammation of the cerebral mass, or an abscess. A wound of the skull may cause death without a warning, setting in either with convulsions or coma. In order to show how slight an injury may take the life of an individual, the speaker presented a specimen obtained twelve years ago, where a man was cut in a fight on the head, the injury being, however, scarcely perceptible, and yet death occurred in twenty-four hours. At the post-mortem examination a small scalp wound was found, underneath which there was an extravasation of blood; on reflecting the scalp it was discovered that the skull had been pierced with a small pocket knife, severing a branch of the middle meningeal artery, the cut extending to the depth of half an inch.

This man might have been struck a hundred times about the head in other situations, and yet he might have escaped much injury. The injury was not recognized during life; if it had been recognized the trephine might have saved this man's life, as the hemorrhage could readily have been stopped with a little white wax. Another man was struck in the head with an ice-pick. Paralysis of the right upper extremity, but not of the face, resulted, and two weeks afterward, when Dr. Conner first saw him, a hardness was to be felt at the seat of the injury, as if the pick had been broken off. The doctor at once removed a button of bone with the trephine and came upon the abscess cavity, which he evacuated, but the man died in two or three days. The cavity was not very large; it was situated at the superior portion of the frontal convolution. The symptoms following the injury in this situation ought not to have been produced according to our present understanding of localization of the brain. If the crown of the trephine had been applied in this case immediately after the injury it would have permitted an outflow of fluids, and prevented these serious symptoms.

The next specimen, obtained from Dr. E. W.

Walker was one of singular interest. A boy being provoked at a man, picked up a piece of a broken pane of window glass and threw it at the latter, striking him in the head. The man went to bed, but was found dead the next morning. An examination showed a piece of the glass sticking fast in the skull. Had the piece been removed immediately there might have been a chance of life. Death resulted from extravasation of blood. Sub-cranial extravasation of blood is not necessarily fatal; the speaker had himself saved a patient's life by trephining and removing the clot.

A practical lesson to be drawn from these illustrations is, that a careful examination ought to be made of every head where a punctured fracture is suspected, and if such be found it is the wisest course to apply the trephine. There is no more danger in removing a button of bone from the head than from the tibia. The special danger of these injuries lies in lesions underneath the skull. It is not necessary to carry out all the extreme precaution for antiseptics, yet with this method the results have been still better than by any other method. The speaker had seen quite a number of cases, where death would have resulted if the treatment had not been active.

The speaker had occasion, in preparing an article on this subject some time ago, to look up the authorities, and he was struck with the many instances of recovery from a gunshot wound in the brain on record. There is this difference between a gunshot and a pick wound, that the ball in its course is apt to leave a sufficiently large opening behind it for drainage. The speaker was rather skeptical that when a ball strikes a piece of bone there is no injury except that made by the surgeon in the operation. If he were thus injured he would rather have the pieces removed than left in the brain. We are not now so far from a decision when to use the trephine as a good while ago. The mere cutting of bone does but little damage, and when a conical crown is used the dura mater can be sufficiently protected. There is not so much danger from injury to the dura mater as from leptomeningitis later; and this is prevented by the removal of the irritating bodies and the securing of free drainage. To show how much injury the brain will tolerate, the speaker mentioned the case of a convict who tried to injure himself by driving pieces of wire into his head, and yet without doing any damage. Certainly these are rare cases, but they show that we need have no exaggerated fear of injuring the dura mater, when the constant injury caused by the presence of bone is so much more dangerous.

Lumbago may be quickly relieved by binding a piece of enameled cloth, such as is used to cover tables, over the loins outside of the flannel shirt. Profuse perspiration is produced which rapidly relieves the pain.—*Sci. Am.*

PUERPERAL SEPTICÆMIA, ITS NATURE AND TREATMENT.

The following by F. P. Atkinson, M.D., will be found in the *Practitioner* for March:

Although puerperal septicæmia is no longer the scourge it used to be, I suppose no medical man passes through his professional career without losing at least one case from this disorder. As regards its nature, I cannot help thinking it will eventually be found to arise either from the infection of erysipelas, or the absorption of decomposing animal matter, either generated within the uterus from the retention of pieces of placenta, membrane, or clots (the last named especially being the result of imperfect contraction), or conveyed by the nurse or medical attendant from without.

Some assert that it most frequently has its origin in the infection of scarlatina, but there are certainly some very strong facts to be brought forward in opposition to this idea. 1. Cases have over and over again been reported where the parturient woman has been the subject of scarlatina, and the peculiar symptoms of puerperal septicæmia have been entirely absent, and also where there have been cases of scarlatina even in the same bed with the parturient woman, without the occurrence of any ill effects. 2. I have been credibly informed by a medical man that he was once called away from a case of scarlatina he was watching to attend two cases of midwifery, and that neither of the lying-in women had any unfavorable symptoms afterwards. 3. I have also been told, and my informant is willing to swear to the fact, that one medical man attended three cases of confinement when his hands were freely peeling from scarlatina, and that not one of these cases had anything the matter subsequent to their confinement. In spite of these facts, I believe that serious harm might result were pus from the ulcerating surface of the tonsils to come in contact with an abraded surface of the uterus or vagina.

In treatment of this as of all other kinds of pyrexia, it is important to inquire first of all as to the cause or the increased body-heat. In ordinary cold, bronchitis, pneumonia, etc., the prime cause is diminished heat-loss, owing to suppression of perspiration, and as soon as the skin begins to resume its function, recovery at once begins to take place; but in septicæmia the cause of the increased body-heat is increased chemical action, owing to the presence in the blood of a greater or less number of disease-germs, and the treatment has to be directed towards checking their growth and life. If this is successful, the cutaneous capillaries begin to dilate and the temperature gradually to fall. In some cases the skin perspires profusely and yet the body-heat remains persistently high, but this results from vaso-motor paralysis and is a symptom of very grave import.

The medicines we have at command for checking the life of disease-germs are quinine, resorcin, kairine, salicine, carbolic acid, boracic acid, ether, etc. In the treatment of puerperal septicæmia quinine is particularly useful, inasmuch as it is not only a strong germicide, but also produces a contractile effect on the uterus and prevents absorption. It is a good plan to administer from two to three grains of quinine with five minims of tinct. digitalis, and from three to five grains of resorcin alternately, every two hours.

If necessary to bring down the temperature rapidly, an ice-bag may be applied to the head and one to the spine, while the body may be sponged with vinegar and water. The uterus should be well syringed out with permanganate of potash (a drachm of Condly to the pint of water) three or four times daily, while the temperature remains high. Plenty of good liquid nourishment should be given, and brandy must be administered according to the severity of the disease. By the adoption of these means most cases may be led on to a favorable termination.

A CASE OF ACTINOMYCOSIS

Dr. W. Knight Treves reports the following case in the *Lancet*, for January 19, 1884 :

P. C., aged 45, was admitted to hospital August 17, 1883, supposed to be suffering from a scrofulous affection of the glands of the neck. He is a muscular man with a good family history. His illness began sixteen months before admission, with inflammation about the neck and angles of the jaw, which, however, only kept him from work for two or three days. He has lived well, and never had cattle to look after. A lump by the angle of the jaw followed the inflammation, which was incised. Subsequently other swellings formed. Over the angle of the jaw, and in the posterior triangle of the neck were three ulcerated and fungating surfaces, those by the angle of the jaw being about one inch and that in the posterior triangle about two inches in diameter. There were tumors over the collar bone, the second rib, and the fourth costal cartilage near the sternum, each of which was in a direct line, and had followed in regular order the one described as existing in the posterior triangle. These tumors resemble each other in appearance ; they are smooth and evenly formed, and are in shape as nearly as possible a half a sphere ; the upper one is two inches in diameter, the lower one an inch, and the middle one intermediate in size ; they have an elastic, semi-fluctuating feel ; the skin over the upper one is thin, red, and evidently about to give way ; the skin of the middle one is also discolored ; that of the lowest is normal. To the right and left of these tumors are two nodules about the size of a marble, apparently the same

thing in process of formation. The discharge was thin and serous, and contained minute yellowish masses, and disintegrated tissue, and had a peculiarly offensive and sour smell. The patient declined operative interference. He remained in the hospital till December 7, the progress of the case being gradual loss of flesh, formation of the lumps on the other side of the neck, and in the axilla. The three tumors described became broken down, and he presented before his discharge the appearance given in the woodcut which is from a photograph. The appearance of these tumors resembled nothing that I had ever seen before. The case was certainly not scrofulous, nor was it like any new growth with which I was familiar. I arrived at the conclusion that it was an example of the disease known as actinomycosis. This diagnosis was confirmed by the discovery under the microscope of bodies which I believed to resemble the fungus described as peculiar to this disease. So far as I can ascertain, this is the first case of actinomycosis described in this country.

THE BEST TIME FOR ADMINISTERING MEDICINES.

The Midland Medical Miscellany has the following article on this subject : Before or after meals ? Such is the question often asked of the doctor, but the answer is not always ready. Medicines that are irritating should be given after meals, when the stomach is full, viz., the salts of copper, zinc, iron and arsenic, in large doses. Small doses, intended to act on the stomach terminals of the vagi, must be given when the organ is empty. Chemical reasons also have their influence ; thus, oxide and nitrate of silver, intended for local action, should appear in the stomach during its period of inactivity, lest, at other times, chemical reactions destroy the special attributes for which these remedies are prescribed. Iodines and the iodides further illustrate this point. Given on an empty stomach they promptly diffuse into the blood, but if digestion is going on, the acids and starch form products of inferior activity, and thus the purpose which they were intended to subserve is defeated. Substances prescribed to have a local action on the mucous membrane, or for prompt diffusion unaltered, are preferably given before meals. The condition of the stomach veins after meals is such as to lessen the activity of diffusion of poisons, and hinders their passage through the liver. It follows that active medicaments in doses near the danger-line, are more safely administered after meals.

When shall acids and alkalies be given, before or after meals ? First, as to acids. When acids are prescribed with the view to check the excessive formation of the acids of the gastric juice, they may be given before meals—as, by the laws of

osmosis, they will determine the glandular flow of the alkaline constituents of the blood. The same reasoning would hold good when the alkaline condition of the blood was in excess ; osmosis being favored, the acid would reach the blood more readily. Second, as to alkalies. These may be given just before meals, when the acid forming materials in the blood diffuse into the stomach glands, and after digestion is completed, when the alkalies diffuse directly into the blood, without interference from the contents of the stomach. An alkali taken during the time when the reaction of the stomach juices should be strongly acid, must necessarily hinder, if not arrest, the digestive process for the time being. The metallic salts—notably corrosive sublimate, alcohol, tannin, and some other agents—impair or destroy the ferment, or digestive power, of pepsin. Wine that is intended to act as a food, is most beneficial when taken slowly during the course of a meal. The objection as regards the ill effect of alcohol on pepsin, is not applicable here, except to the stronger spirituous wines in large quantities, for the ordinary medicinal wines do not have sufficient alcoholic strength to injure this ferment. Iron, phosphates, cod-liver oil, malt, and similar agents should, as a rule, go with food through the digestive process, and with the products of digestion enter the blood.

THE TREATMENT OF PELVIC CELLULITIS FOLLOWING PARTURITION.

Dr. Grailly Hewitt concludes an article in the *Med. Press*, November 21, 1883, as follows :—

A few words with respect to the treatment : A remarkable feature in these cases is their tendency to chronicity. They are always tedious and difficult to cure, and the cure depends more on attention to diet than on any other element of the treatment. Rest, of course, is an essential ; but the nutrition requires careful consideration. With regard to the subject of food : Deficiency of food may predispose to cellulitis in a patient in whom other factors in its cause may be present ; or it may render an already-existing case of cellulitis less amenable to treatment. In the case before us the quantity of food taken was perhaps only one-third of the total amount required by the healthy subject. This created a weakness which showed itself in various ways. Under these circumstances there is a great indisposition to take food, and if only three stated meals a day are provided, a very small amount is taken ; the patient becomes exhausted in the intervals, and when meal-time comes is not able to take nourishment. Hence the quantity taken is not enough to induce activity in the nutrition process, but only enough to keep up a condition of *statu quo*. To stimulate nutrition, articles capable of ready assimilation must be selected—

Brand's essence, beef tea, milk, etc., with a fair amount of stimulant in the shape of brandy, and this must be given very frequently, every hour or so. Under this treatment the appetite will rapidly improve, and in a week or so, in all probability, solid food will be taken with zest. As subsidiary treatment, poultices may be applied to the abdomen to relieve pain and assist resolution, and if the latter is very severe a little opium is indicated. The bowels should be daily opened by the administration of a mild laxative. Some medicine, in the shape of dilute nitro-muriatic acid with a little tincture of orange, is often useful as a stomachic and tonic ; and later on iron and quinine may be given with advantage.

IODOFORM IN CHRONIC CYSTITIS.

Dr. David Prince, of Jacksonville, Ill., *St. Louis Med. and Surg. Journal*, has relieved several cases of chronic cystitis by the use of iodoform. A soft catheter is introduced into the bladder, which is by this means thoroughly emptied, if there is any residual urine which the patient is unable to void voluntarily. Then fifteen cubic centimetres of the following preparation are to be injected : Five grammes of iodoform are ground with twenty-five grammes of starch, and the whole is "moistened" with forty cubic centimetres of water. The mixture is to be injected daily and allowed to remain. The medicament is not entirely expelled at the first subsequent passage of urine, as the heavy crystals of iodoform adhere to the mucous membrane. Starch was the substance chosen to incorporate with the iodoform because it was free from irritant properties. This treatment speedily allays the irritation of the vesical mucous membrane, and with it the painful reflex contraction of the muscular coat of the bladder. The relief of this reflex contraction greatly increases the available capacity of the bladder. "In the case of a gentleman who had suffered greatly for several years, there was no pain after the first introduction of the iodoform. He thought after a four days' treatment that the capacity of his bladder had been doubled." Dr. Prince believes that the same treatment will be found beneficial in gonorrhœa. He thinks it will prove better than the use of pencils or bougies of iodoform and gelatin, because the iodoform, as he employs it, adheres to the urethral mucous membrane, and its action is therefore kept up for some time after the injection has been allowed to escape. The action of iodoform when used in pencils or bougies can last only while they are retained. Dr. Prince also suggests that the treatment of moderate strictures of the urethra, accompanied by vesical inflammation, may be advantageously preceded by the use of iodoform and starch. Mechanical dilatation, electrolysis, or other measures may, of course, be required afterward.

SOME NOVELTIES IN THE TREATMENT OF NASAL POLYPI.—Dr. W. Spencer, Watson (*Lancet*,) says: In the removal of polypi, whether by snare, forceps, or cautery, it is very difficult to be quite sure that the whole of the growths has been extracted. It is probably due in part to this uncertainty that polypi are so liable to recur. Often, no doubt, rootlets or fragments of one or more of the growths remain behind. If therefore we can by more thorough extirpation avoid this uncertainty the chance of recurrence is so far diminished; for though it is possible that the diseased mucous membrane has a tendency to reproduce the same morbid overgrowth, yet, *ceteris paribus*, the more complete the operation the less will this tendency show itself. The object then to be attained is to detach the polypi as close to the bone as possible, and it is even better in some cases to remove a portion of the turbinated bones with them. It is generally tolerably easy to get away those polypi which hang near the anterior apertures of the nostrils, but for the complete removal of those more deeply situated the usual methods are often insufficient. To meet this difficulty I have devised the polypus ring-knife (made by Messrs. Krohne and Sesemann). It consists of a rod of softish steel (which allows of being somewhat bent to any desired curve), which, with the handle and the ring-knife, measures eight inches and a half. The handle resembles that of a door-key, and is large enough to admit two fingers; at the other extremity is the knife, of oval form and one inch and a quarter long, being at its widest part five eighths of an inch broad. The outside of this ring is thick and blunt, its inside beveled, and with a cutting edge extended round the semicircle farthest from the handle. The knife when used is passed along the lower part of the nostril with its sides parallel to the septum, until it reaches the posterior aperture of the nares. At the same time the forefinger of the left hand is passed behind the velum palati and hooked up in the posterior aperture of the nostril. If there are any pendulous portions of polypus in the pharynx they can now, by a little manipulation, be slipped through the ring of the knife, which is then directed by the finger toward the outer wall of the nostril. The instrument is then slowly withdrawn, and, as it passes forward, is made to scrape away the polypi from their attachments to the bone. The operation is necessarily painful, and can be best done under an anæsthetic, the mouth being kept open by the use of a Mason's gag. The instrument thus used can be directed with considerable precision, and is, I think, preferable to forceps, when the polypi are deeply seated, and especially when of the sarcomatous or firm myxomatous variety. If the antrum is involved, the blade may be passed into it after the curve of the shank has been somewhat altered. But to reach the extreme depths of this cavity the ring-

knife used by Meyer for adenoid vegetations of the pharynx is well adapted. I have succeeded quite recently in clearing out the antrum with these two instruments in a case of recurrent myxosarcomatous polypi, without laying open the alæ nasi. In this case, however, I followed up the treatment by the application at intervals during several months after of the acid pernitate of mercury to spots on the surface of the mucous membrane, at which there seemed a tendency to return of the growths. The application of nitric acid, or acid pernitate of mercury or similar fluid escharotic, in such a narrow channel as the nostrils seems at first sight a somewhat formidable and dangerous proceeding; but when carefully done with the acid in the platinum canula, and under a good light from the short-focus mirror, the proceeding is not really dangerous nor painful. The platinum canula is guided carefully to the spot to be cauterized. A pencil of wood previously dipped into the acid is then passed along it, and when it reaches the aperture in the canula is made to press against the diseased tissue. The surrounding parts are thus completely protected, and if the point charged with the acid is again drawn into its sheath before the instrument is withdrawn only a limited area of mucous membrane is touched. A slough, of course, forms, and becomes detached in the course of a week, or less. This plan has succeeded very well in some of my cases. It should, I think, be employed in all cases of polypi, whether gelatinous or sarcomatous, after the removal of the principal mass, but, of course, only after such an interval has elapsed from the time of the first operation as to allow of all swelling having subsided, and so to enable the operator to get a clear view of the parts with the rhinoscopic mirror. From three weeks to a month from the first operation is about the best period. It is, I think, only by repeated applications at intervals of a few weeks to several months that we can hope for a satisfactory result. I am not prepared to say that this plan is never followed by recurrence of the diseased growths, but I think it offers a good prospect of retarding it in all cases, and it has certainly appeared to me to delay the recurrent form of polypi from reappearing for an indefinite time.

INCISION AND DRAINAGE IN PURULENT PERICARDITIS.—With regard to operative surgical interference in pyo-pericardium, most authorities agree in considering it a delicate and hazardous operation, to be undertaken as a last resort, and only by means of the aspirator or a fine trocar and canula.

This treatment by the use of an exploring trocar was recommended by Ramberger and Friedreich, with the subsequent injection of chlorine water or iodine, or irrigation by detergent antiseptic solutions, and is referred to also by Fothergill, who regarded it as a forlorn hope, but thought it capable

of yielding relief. The practice approved by F.T. Roberts is that of removal of the purulent collection by the aspirator; but he gives this recommendation with the warning that it should not be rashly practiced. Bristowe, who approves of surgical interference in pericardial suppuration, gives the details of the operation; the most eligible spot for puncture he considers to be one towards the inner extremity of the fourth or fifth interspace close to the sternum, and suggests that the tissues be divided with the scalpel, one by one, until the parietal layer of the pericardium is reached, and then to puncture carefully with a fine trocar and canula; believing it advisable also to wash out the cavity, he uses a weak solution of chlorinated soda or potassium permanganate. The preliminary use of a fine aspirating needle for diagnostic purposes is suggested.

Dr. Austin Flint, Sr., says that in suppurative pericarditis aspiration is always indicated, but he also states that if after repeated aspirations pus continues to reaccumulate, it is very evident that a permanent opening into the pericardial cavity, with injections, affords the only hope of effecting a cure.

Dr. Samuel West, at a recent session of the Pathological Society of London, reported a case of purulent pericarditis treated by free incision, in a boy fourteen years of age; twenty-four ounces of pus were evacuated (*Medical Times and Gazette*, December 8, 1883.) This makes the third case in which the pericardium has been laid freely open for purulent pericarditis. Prof. Rosenstein reported the first case, of a boy whose pericardium had been twice tapped, who recovered, in spite of a secondary attack of left-sided pleuritis. The second case had been under the care of Dr. Samuel West also; it was an idiopathic purulent pericarditis, in which the same treatment was followed by complete recovery. In the third case death occurred from other causes; the post-mortem showed a large abscess of the thigh; but the cavity of the pericardium had been nearly obliterated in the short space of two weeks. He expressed the opinion, in presenting this specimen for examination, that opening the pericardium is not a more hazardous proceeding than opening the pleura or the peritoneal cavity, if done with the same precautions.—*Med. Times*.

DANGER OF ARTIFICIAL RESPIRATION DURING A SURGICAL OPERATION—The Vienna correspondent of the *Northwestern Lancet and Med. Review*, who by the way, takes a practical view of things as they are in Vienna, reports a very interesting case which occurred in the clinic of Billroth. He, Billroth, undertook the removal of a medium sized goitre from the neck of an otherwise healthy young man, a few days ago. On administering the chloroform mixture which is used at this clinic, (A. C. E. mixture), the patient became very pale, inasmuch that

the operator remarked upon it. When the operation was commenced the pulse ceased. Artificial respiration was employed and the patient seemed better, and the operation was resumed for a moment, when both respiration and pulse ceased. Despite artificial respiration and galvanism, the patient did not rally. After twenty-five minutes tracheotomy was performed, and direct artificial respiration with a bellows tried, though the operator said he did not expect more from it than from the other procedures. After thirty-five minutes faithful work, during which the great surgeon showed not the least agitation or change from his deliberate quiet demeanor, except that the tones of his voice seemed a trifle sadder, he said: "I believe we must give it up. Wash off the body and carry it out." Another patient was brought in, and the operations proceeded as if nothing had happened. We were sure it was a death from chloroform, though after the operations were done Billroth said he did not know what was the cause of death. He was quite sure it was not entrance of air into the veins, as he had carefully ligated all and no gurgling sound had been heard. Next day, however, he reported that the autopsy showed the cause of death to be entrance of air into the veins, right heart being found full of frothy blood and air.

Probably the most reasonable explanation of all the facts in the case is the following: The patient did not act well under the anæsthetic and becoming in danger the operation was stopped to practice artificial respiration some small veins being left open; the energetic handling of the patient, greatly facilitated the sucking in gradually of air until the right heart was filled. Thus in fighting the dread chloroform syncope, the absolutely fatal condition was greatly assisted if not caused.

To many it will seem that it is arrogance itself for any one here in the West to suggest anything to these great men, but this is a free country and we can express our astonishment that they are so slow to appreciate the value of ether and its proper administration. Whilst the immediate cause of death is given as the entrance of air into the veins, the probability is that if ether alone had been used there had been no necessity for the artificial respiration, and consequently no admission of air into the veins.

There is another lesson, which we in the West have learned, and which the extensive operators in Germany would probably also learn if they distributed their work more among those who were equally capable and gave themselves more time for reflection; that, if we must use chloroform and get into difficulty the lowering of the head constitutes an important item among the means of restoration and that when the heart has ceased to beat, good hot applications to the region of the heart would theoretically be much more promising than the aimless efforts usually made with the battery.

HYDRASTIS CANADENSIS IN GYNECOLOGY.—Dr. Schatz, of Rostock, read a paper on the above subject at a recent meeting of the German Gynecological Society.

He is of opinion that the medicinal treatment of the diseases of the female sexual organs has been crowded too far into the back-ground by the operative treatment; that now-a-days the knife is not rarely resorted to in cases in which favorable curative results could be attained by less formidable measures. The author thinks that, especially in functional disturbances of the uterus and ovaries, in menstrual anomalies, direct or reflex nervous, or even congestive troubles, medicinal treatment ought to be tried if the difficulties are but moderate, if an operation is dangerous or mutilating. He calls attention to the fact that often accidental changes in the mode of life, of the climate, psychical alterations, nervous irritations, and finally medication prescribed for other purposes are followed by obvious and unexpected changes in the affections named.

With this view, S. experimented with Hydrastis. He used the fluid extract in about fifty cases. Two-thirds of these were utilized in estimating the value of the drug. In general, it seems to act on the mucous membranes by exciting their vessels to contract. In the female genital apparatus, it seems not only to diminish the blood supply of the mucous membranes, but to act on them as a whole. It is remarkable that the remedy is often effective in cases in which ergot has failed or even has rendered the symptoms worse.

Favorable results were obtained by S. mainly in metrorrhagias due to myomata (ergot had long been used in vain), in hæmorrhages in the puerperium, in menorrhagias of young persons from fifteen to eighteen years of age, finally also in those forms of endometritis in which curetting had failed. In most cases, he commenced the use of the drug one week before the onset of the menses; where the catamenia recurred with undue frequency, even longer previous to the normal date of their appearance. In several cases, the flow became not only less profuse and shorter in duration, but several times it failed to set in altogether. In the case of myomata, too, the hæmorrhages disappeared often for months. The incidental effects of the drug generally were only agreeable in their nature. Particularly noticeable was an increased appetite. Once only a certain lassitude occurred; in another case, states of exaltation. The dose of the fluid extract is about twenty drops three times a day.—*American Journal of Obstetrics*.—[It has also been highly extolled in the treatment of dysmenorrhœa.]

ED. LANCET.

SALICYLIC ACID IN CEREBRO-SPINAL MENINGITIS.—Dr. D. C. Ramsey, in an article in *St. Louis Courier of Medicine* concludes as follows:

1. The analogy existing between rheumatism and cerebro-spinal meningitis would suggest and be good reason for the use of similar remedies in both diseases.

2. Salicylic acid being the best remedy, almost a specific in the treatment of acute articular rheumatism, would be a strong indication for its use in cerebro-spinal meningitis.

3. It produces marked reduction in the temperature; the fever being thus lowered, the tissue-destruction and the onward progress of the inflammation is checked, thereby giving the patient rest.

4. It controls the intensely annoying metastatic pains of head, back, elbow, and knee, giving the patient ease.

5. It exerts a direct influence for good over the inflammation itself, and can be taken in frequent large doses without bad effect; having given a boy fifteen years of age half-drachm doses every four hours for three or four days, with the only result of a great benefit in all the symptoms connected with the disease is, I think, conclusive evidence of its harmlessness.

6. Its good effects are soon apparent, and it does not interfere with the use of other measures of relief, as ice, blisters, etc.

7. The best mode of using the remedy is to administer large doses frequently. For adults begin on doses of fifteen grs. repeated every two hours, and increase the dose as may be found necessary to obtain the desired effect, to ℥ ij., at intervals of two hours, if need be. When the disease is under control, which will be determined by the reduction in temperature, relief of pain, and placid countenance, decrease the dose, give at longer intervals, but still continue the use of it in small doses as long as the least symptom is present indicative of the disease.

Having never read or heard of salicylic acid being used in the treatment of cerebro-spinal meningitis, and my good success with its use in this fearful epidemic being afterwards verified by Dr. J. B. Weever, of this place, I hope to induce others to give this remedy a trial, and by so doing I think they will be enabled to see very happy effects from its use, and thereby be highly gratified with the results.

SORE THROAT IN CHILDREN.—Dr. Henry Ashby, (*Practitioner*,) mentions four principal varieties:

1. Simple tonsillitis. 2. Scarlatinal tonsillitis. 3. Pseudo-diphtheritic. 4. Diphtheria.

Weakly and scrofulous children are especially subject to the first. It is oftener seen as a complication of alimentary disorders, as those of liver and stomach, than of the respiratory tract, as bronchitis and laryngitis. It frequently precedes rheumatic attacks. It may be the result of the scarlatinal poison. In proof of this he cites an interesting series of eight cases occurring in a hospital

ward within a few days. Several nurses also took the disease. The first patient attacked, it was found, had been exposed to the genuine scarlatina a few days before. None of these cases had an eruption. One, a patient in previously bad condition, died. No sanitary conditions prevailed.

In view of the difficulty—at times the impossibility—of diagnosing scarlet fever from simple tonsillitis, the writer recommends the isolation of all children with febrile sore throat as long as faucial congestion remains. The points in favor of scarlatina are: The presence of vomiting and diarrhoea in the stage of invasion; a pulse of 130, 160; not necessarily a high temperature; marked injection of the uvula, pillars of the fauces and tonsils. Later, the enlargement of the cervical lymphatics, with tenderness; low exudation over the tonsils and uvula, make the diagnosis of scarlatina tolerably certain.

Under pseudo-diphtheria, the writer includes a class of cases which are said to bear the same relation to diphtheria that epidemic tonsillitis bears to scarlatina. It prevails where diphtheria does, is attributed to sewer gas and other poison. They differ from it in that the cervical glands are rarely involved, the membrane is less tough, the nasal mucous membrane unaffected, the urine does not contain albumen, the usual sequelæ of diphtheria are absent. The prognosis is always good. The duration is rarely over a week.

The sore throat of diphtheria is differentiated from aginose scarlatina, by the fact that in the latter we rarely have true membrane. A yellowish exudation may cover the tonsils, perforations and even sloughing of the palate may occur, and there may be much external cellulitis, but the leathery, whitish, adherent exudation of diphtheria is absent. The amount of albumen in the urine of scarlet fever is usually slight; in diphtheria it is often fifty per cent.

THE USE OF THE OLEATES IN SKIN DISEASES.—In a communication on the above subject in the *Medical and Surgical Reporter*, March 15, 1884, Dr. Stelwagon speaks as follows: Of all the oleates so far introduced for the treatment of diseases of the skin, the following may be considered as possessing therapeutic powers which experience has attested: oleate of mercury, oleate of zinc, oleate of lead, and oleate of bismuth. The other oleates have as yet failed in adequately supporting any attested claim to curative powers; further experience in their use may, however, prove them worthy of a permanent place in dermic therapeutics. In ordering the oleates several points are to be kept in mind. If the action of the proposed ointment is to be mainly protective, then the oleate is best made up with one of the paraffinates: if there is to be a certain amount of penetrating power along with a protective influence, then a mixture of lard or oleic acid with a paraffinate is to be prescribed

as the base of the oleate ointment; again, if absorption is the main point aimed at, then the oleate compound should be made up of lard, oleic acid, or a combination of the two. In some cases (and they are by no means few) the oleates are found to disagree; instead of an improvement, a slight or marked aggravation occurs. In not a few instances this may be due to the bad quality of the oleate used, but that it may occur with oleates which are of the best manufacture is beyond question. Oleates, if properly prepared, will keep almost indefinitely; but if prepared in the old way, with an excess of oleic acid present, they will frequently be found to deteriorate. In conclusion, it may be said that the oleates are to be considered merely as additional means of treating cutaneous diseases, and are in no sense to be looked upon as panaceas, for often enough they must be discarded to give place to the older and tried methods of dermic medication.—*Med. Record.*

GALLIC ACID IN HÆMORRHAGE FROM THE URINARY ORGANS.—Lionel S. Beale, in the *LANCET*, recommends the use of gallic acid in this affection in large doses, and persisted in for several days. As gallic acid probably acts according to the strength of the solution, which bathes the bleeding tissue, it is necessary to insure the introduction of a certain quantity in the blood by the frequent administration of successive doses; as it soon passes away from the blood, being carried off in the urine, we must give it in quantity and often enough to more than compensate for this loss. He has found it valuable in chronic bleeding from the surface of the mucous membrane of the pelvis of the kidney, ureters, bladder, and urethra, and from villous growths, as well as in the very obstinate hæmorrhage from large fungous tumors of the kidney and bladder. The remedy should be given in frequent doses, day and night, until the bleeding is very decidedly reduced in degree, when it may be ordered once in six hours, or less frequently. Gallic acid seldom disagrees in any way. It does not cause constipation, and even when the crystals are swallowed in a state of suspension in water or mucilage, the stomach is not disturbed by their presence. The glycerine of gallic acid is, however, the most pleasant form in which to prescribe the remedy. This contains one part of gallic acid in four. Forty minims will contain ten grains, and may be given in distilled water, peppermint, orange, or other water. Dr. Beale has given ten-grain doses every three hours, without intermission, for three weeks, no objection having been made on the patient's part.

THE SIGNIFICANCE OF DOUBLE SCIATICA.—In a recent clinical lecture, Professor Charcot described the case of a woman, aged sixty-one, who had been operated on several times for scirrhus of the breast. She developed very severe double

ciatica, with pain in the region of both anterior rural nerves. The pains were exasperated by the erect position, so that walking became impossible. There was tenderness in the lumbar and sacral region of the spinal column, but there was no muscular atrophy, alteration of reflexes, or disturbance of the functions of the bladder or rectum. Professor Charcot insisted that double sciatica is always symptomatic, and the causes are (a) diabetes; (b) certain spinal diseases, for example, locomotor ataxy and meningo-myelitis; and (c) some alteration in the nerves themselves. There was no sugar in the urine, nor any evidence of those spinal affections; and in the absence of any sign of a tumor in the pelvis the readiest explanation was cancerous invasion of the vertebral column, causing pressure on the nerves. Secondary cancer of the spinal column was held by Cazalis to be very common, especially after scirrhus of the breast, but it may be also met with in cancer of the stomach. In practice it is important to note that the presence of double sciatica in cancerous patients indicates metastasis, and contra-indicates operative interference. Conversely, severe neuralgic pains in patients at the age for cancer should suggest a careful examination of the breasts, the stomach and the uterus. Such pseudo-neuralgic pains are the ordinary clinical signs of vertebral cancer, but a fungous mass may project from the spine, in which case the vertebra will be infiltrated, and the consequences will be similar to those of Pott's disease.—*Bost. M. & S. Jour.*

BRONCHOCELE TREATED BY THE SETON.—Mr. Henry Smith (*Lancet*, January 5, 1884), *Can. Med. and Surg. Journal*, reports two cases of bronchocele successfully treated by the seton. The first case was that of a man who had a great enlargement of the right lobe of the thyroid, which caused cough, dyspnoea, and general weakness, so that he could not attend to his duties. He was advised to have the tumor removed, but refused, so Mr. Smith, after puncturing the tumor with a small trocar, passed a needle around by a double empen thread through the opening, carried it deeply into the substance of the swelling, and brought it out on the other side. The threads were tied together and left to act as a seton. Great local irritation was produced, accompanied with a free purulent discharge. As there was considerable fever, the seton was withdrawn and a drainage tube introduced. The tumor gradually decreased, and the man left the hospital still wearing the tube. After a time it was taken out, and when the man was exhibited to the students, there was no appearance of the tumor beyond a very slight thickening, and the man was in perfect health. The second case was that of a woman, aged sixty-eight, who had suffered from bronchocele for sixteen years. The tumor involved the

whole gland, and produced much distress, with dyspnoea. A seton was introduced and left in for sixteen weeks; free discharge ensued, and the tumor rapidly decreased in size. The difficulty of breathing disappeared, and when shown to the students, there was hardly any trace of the tumor.

OVARIOTOMY IN INFANCY.—Dr. Roemer, assistant-surgeon to the Augusta Hospital, Berlin, has recently published, in the *Deutsche Medicinische Wochenschrift*, a case of ovariectomy performed by him on a child aged one year and eight months. At the birth of the child, the midwife observed that its abdomen was much distended. There was little difficulty in diagnosis, and the pelvis was readily explored through the rectum. The tumor was removed last August, under corrosive sublimate spray; it was "of the size of a child's head" and there was slight adhesion of the omentum. The pedicle was long and thin, and was secured by a double catgut ligature. The right ovary was the seat of disease, the left was perfectly healthy. The tumor was dermoid, containing hair, bone and cartilage. After the operation, the child was tied gently but effectually on to its cot, and opiates were given when required. It was fed on cold milk and wine. The highest temperature was 101.6° ; this point was reached on the evening of the second day. On the fifth, the child's bowels were freely opened by five minims of castor-oil administered twice; on the twelfth, the abdominal sutures were removed. The child recovered perfectly. Dr. Roemer gives the following statistics of ovariectomy performed on children. One of the youngest cases next to his own was under the care of Dr. Neville of Dublin: the patient was two years and eleven months old, but only survived the operation for two hours. Busch operated on an infant aged two, Alcott on a child aged three; both cases died. Schwartz operated successfully on a child aged four; Barker on two, and Knowsley Thornton on one aged seven; and Spencer Wells, Cupples, and Chenoweth, each on one child eight years of age.—*Brit. Med. Jour.*

[To these should be added one by Dr. Hingston, of Montreal, on a child eight years of age, with recovery.—*ED. LANCET.*]

TREATMENT OF TONSILLITIS.—Dr. S. Solis Cohen, (*Med. News*), gives the following treatment, which he says is pursued at the Philadelphia Polyclinic with eminent success:

1. In simple inflammatory tonsillitis, take two fluid drachms each of the ammon. tinct. of guaiac. and the comp. tinct. of cinchona, mix with six fluid drachms of clarified honey and shake together until the sides of the vessel are well coated; add gradually a solution of eighty grains of chlorate of potassium in four ounces of water, shaking meanwhile. This is to be used as a gargle every one-

half to three hours. Relief is usually experienced within a few hours and recovery is prompt. A saline cathartic may accompany the use of the gargle. None of the cases seen suppurated, and if seen within the first twenty-four hours such incidents are very unlikely.

2. In rheumatic or constitutional tonsillitis (characterized by intense pain in swallowing, causing great accumulation of saliva unwillingness to swallow, with slight, perhaps no congestion of throat and subsequent fever; one or both tonsils becoming enlarged after some hours as the febrile symptoms decline, and muscular or joint rheumatism sometimes develop later), after a saline cathartic, give the following in tablespoonful doses every two hours.

R	Sodii salicylate,	3 ij.
	Ol. gaultheriæ	M j,
	Liq. ammon. citrat.,	
	Syrup simp., aa	3 ij.

Lengthen the intervals as the pain subsides. Pieces of ice or guiac gargle promote comfort, and the stiff neck is best relieved by faradization. Salicylate of quinia or cinchonidine may be substituted for the above if a tonic be required, in five-grain doses every four to six hours.

LOCAL APPLICATION OF VASELINE IN SCARLET FEVER.—Dr. J. B. Johnson (*Med. and Surg. Jour.*) says: I have found nothing so efficient in relieving the burning and itching sensations of the eruption of scarlet fever as the inunction of the whole body with vaseline. The vaseline is simply used by being well rubbed upon the surface of the body with the hand once or twice a day, and continued as long as the patient complains of burning and itching of the skin. These inunctions soothe and calm the patient in an astonishing manner, and are rarely required beyond two or three days. On the appearance of the stage of desquamation, I have the whole body well sponged once a day for a week with the following wash: R. Hyposulphite of soda, 3 viij; carbolic acid, No. 1, 3 j; glycerine, 3 jss; aqua, 3 viij. M. S.—Shake well, and sponge the body well, after the wash has been made tepid by placing the vial containing it in a pan of hot water.

The sponging should be conducted in a room of equal temperature; and immediately after each sponging the body should be well dried with a soft towel, and the patient protected against taking cold. This process should be continued for at least a week; and it has not only the advantage of healing the new skin, but also lessens the infectious character of the period of desquamation.

THE DANGER OF USING IODIDE OF POTASSIUM INTERNALLY AND CALOMEL LOCALLY AT THE SAME TIME.—In the *Lancet* for March 29th, Mr. T. Davies Pryce, of the Nottingham Dispensary, re-

cords the case of a little girl suffering with chronic interstitial keratitis, who ceased attending at the institution after having been under treatment for four months, and having improved satisfactorily under the internal use of iodide of potassium and corrosive sublimate, with the occasional instillation of atropine. After an absence of three months she returned, and the condition of the eyes was then such as to call for further treatment. The internal treatment was resumed, and calomel was dusted into both eyes, to reduce enlarged conjunctival vessels. On the following day she was seized with a sharp conjunctivitis of the right eye, injection of the circumcorneal zone, and vascular extension on to the cornea. There was vascular irritation of the other eye, but no actual inflammation. Mr. Pryce speculates as to the cause of the conjunctivitis. Dismissing the idea that the simple insufflation of calomel was sufficient to give rise to the trouble, and having satisfied himself that the calomel did not contain corrosive sublimate, he inclines to the conclusion that an iodide of mercury was formed by a reaction between the iodide of potassium circulating in the blood and the calomel applied to the conjunctiva. He refers to similar cases published by M. Hennequin and M. Lagarde, both of whom attributed the result to the formation of an iodide of mercury in the manner suggested. In one of their cases actual sloughing of the conjunctiva took place.—*N. Y. Med. Journal.*

DEATH FROM PASSAGE OF AIR THROUGH THE UTERINE VEINS.—The patient was a healthy powerful woman bearing her second child. The labor ran a normal course, the patient being in the left sided position. Immediately after the expulsion of the foetus the patient was turned on to the back and the uterus pressed upon. The placenta followed quickly and easily, but immediately afterwards convulsive movements supervened and the patient became unconscious. Deep collapse and superficial respiration followed, and then death notwithstanding all efforts. At the necropsy bubbles of air were found in all the veins of the neck of the heart, even to the finest branches, as well as in the uterus, so that the diagnosis which had been made of cardiac paralysis from entrance of air into the circulation was proved to be correct. As neither catheter nor vaginal tube had been passed into the genital pouch, Dr. Gustav Braun of Vienna, whose case it was, gave the following explanation: At the change of position of the patient, air found its way through the gaping vulva the massage of the fundus uteri separated the placenta and forced it out again, but it again entered on relaxation of the uterine walls, and was forced into the uterine veins by the continued massage. The author believes that many cases designated a collapse, *post partum*, and many of sudden death in child bed and labor, are explained by the sup-

osition of the entrance of air into the uterine veins.
—*Med. Press and Circ.*

SUBCUTANEOUS INJECTION OF IRON.—Experimenting on the behaviour of iron within the animal system, Dr. Glacoeke reports in the *Archiv. für Experimentelle Pathologie und Pharmacol.*, that he has found the ferrum citricum oxydatum to be the best form of iron for subcutaneous injection. No reaction takes place at the site of the puncture. The iron is excreted through the kidneys, not through the glomeruli, but through the epithelium of the tubuli uriniferi. The excretion is complete within twenty-five hours. The liver to a greater extent takes part in the elimination. The injections are made in the long dorsal muscles or in the nates. The solution should not be more than one month old, and for adults doses of $1\frac{1}{2}$ grains in a 10 per cent. solution are recommended. In the case of an extremely chlorotic girl, in whom the proportion of hæmoglobin in the blood was 38 per cent. of the normal, it rose after fifty four injections to 82 per cent., and the patient had in the meantime gained sixteen pounds in weight; the menses also, which had been absent for nine months, returned. Good results were also obtained in a case of secondary anæmia from hæmorrhage from the stomach. If too much iron be injected, toxic effects may be manifested, in the shape of general *malaise*, vomiting and weakness. Hærrhoea may also come on.—*Medical Press.*

TREATMENT OF DIPHTHERIA.—Prof. Da Costa says that bichloride of mercury, gr. $\frac{1}{8}$ — $\frac{1}{6}$, every two or three hours, has given him most success in its treatment, though he recommends a saturated solution of chlorate of potassium combined with tonic doses of iron and quinine, where the membrane is not spreading. The best gargle is a solution of thymol, gr. xx to the ounce of water, with a little glycerine added; this may require weakening. Boracic acid in solution is the next best gargle. But one case of tracheotomy, in his experience, performed for laryngeal diphtheria, survived (a boy, aged 11), and he has almost ceased urging it on parents, except in older children. Prof. Da Costa heard Trousseau say, "Fifty cases of nasal diphtheria mean fifty cases of death," but as had cures enough to make him approach a case with more hope and determined to continually inject the posterior nares with the following:—

R. Sodii sulphit. 3 iij
Glycerini 3 ij
Aquæ q.s. 3 iv. M.
—*Col. Clin. Record.*

PRURITUS AT THE MENOPAUSE.—The pruritus so often observed in women at the menopause, or change of life, is well known to be excessively rebellious to treatment, and the suffering caused by

the affection, morally and physically, is often very serious. It is nothing uncommon to see women in the greatest prostration and despondency from the loss of sleep and appetite produced by an insupportable itching. The practitioner has often been disappointed at the little results obtained from the employment of remedies recommended by the greatest authorities, and both patient and attendant despair of success. Dr. Cheron highly recommends the following ointment where the pruritus is localized to axilla, the vulva or thighs, or the abdomen. He declares that if this pomade is applied morning and evening the affection will yield to its influence.

Veratrine, grs. iij. ;

Axunge, " 3 j.

When the pruritus is general over the body, he advises the veratrine to be given internally in pills.

Veratrine, $\frac{1}{3}$ gr. ;

Liquorice powder, q. s.

For 40 pills. 2 to 6 a day.—*Med. Press.*

ADVERTISING PRACTITIONERS.—We are flooded every week with handbills, pamphlets, and newspaper advertisements by practitioners whose names appear in the Medical Directory. These are sent to us by medical men who are jealous for the honor of the profession, and who leave to vulgar quacks the proclamation of their wares and the glorification of their powers. We must not shut our eyes to the fact that we have to deal with men whose titles may be in the Register, but whose tactics are those of the market-place. It is pitiable indeed to find the members of a learned profession plying the arts of a low trade and thriving on the ignorance and fears of the public. We shall be asked what can be done to punish such offenders and abate their numbers? Much is done by themselves to effect their practical disreputement. They may remain on the Register, but not the less are they out of the pale of professional society and classed with market-place pretenders. Henceforth we advise respectable medical men, who are naturally shocked by these practices, to send copies of the bills and advertisements to the presidents of the corporations whose diplomas are thus prostituted, and to urge upon them some rebuke of the offenders.—*Lancet.*

[We most fully and cordially endorse the above statements and regret to say that similar practices are too common in Canada.]—Ed. CANADA LANCET.]

THE SURGICAL TREATMENT OF CEREBRO-SPINAL LESIONS.—On the evening of the 6th instant, Dr. William Macewen gave a clinical demonstration, in his wards at the Glasgow Royal Infirmary, to the members of the Southern Medical Society, on cerebro-spinal lesions and their surgical treatment. Fourteen examples of such treatment were pre-

sented, and eleven patients shown who had recovered from various cerebral and spinal affections under operative interference. The cases comprised compression of the brain from hemorrhage in various parts, abscess of the brain and its membranes, epileptiform seizures from tumour of the dura-mater, hemiplegia, and paraplegia. Cerebral localisation of function guided the operator to particular lesions, and so successfully, that operative measures were invariably followed by good results. In the majority of the cases, Dr. Macewen employed reimplantation of bone to hasten the cure, and with success. The demonstration excited the greatest interest among those present, and all congratulated Dr. Macewen on his cases; for it was apparent that in his hands the prudent and judicious employment of the trephine, under the guidance of cerebral localisation of function, and backed by rigid antiseptic precautions, had undoubtedly saved many of the patient's lives.—*Brit. Med. Jour.*

ATROPHIC NASAL CATARRH.—Dr. Carl Seiler (*Med. and Surg. Reporter*) says regarding the treatment of this affection, the stimulation of the serous glands to a normal action may be brought about by a variety of remedies, such as astringents in various strengths; but in my experience the insufflation into the anterior nasal cavities of finely powdered nitrate of silver, diluted with starch powder has given the best results. Where there is complete absence of the lower turbinated bones, the introduction of a wad of absorbent cotton, which is to remain until washed out, and then be re-introduced by the patient himself, often aids in the stimulation by continually irritating the mucous surface with which it is in contact. Next in effectiveness to the silver powders, I have found a weak solution of ferric alum in the form of a spray thrown into the nasal cavities, and the natural iron water of Cresson springs is peculiarly adapted for these cases.

The internal administration of small doses of bromide and iodide of potassium in combination, on account of their influence upon the nasal mucous membrane, will greatly aid the local treatment. At the same time we must look to the general health of the patient, and administer tonics when their use is indicated. Whenever practicable a change of air should be advised, and the mountain resorts are preferable to the seashore in all cases of catarrhal inflammation of the upper air-passages, especially where the climate is a dry one.

A treatment such as this, carried out for several months, has given, in my hands, most satisfactory results.

THE DANGERS OF NERVE-STRETCHING.—In a recent number of the *Annales de Chlarié*, Westphal reports the following case: A man aged 31,

suffering from paralysis of the lower extremities, with spasmodic phenomena (starting of the limbs, exaggeration of deep and superficial reflexes, disturbance of sensation), was submitted to the operation of stretching the right crural nerve. Immediately after the operation a transient loss of the knee-jerk was noted, with stiffness of the muscles of the right limb. But incontinence of urine and stools with contracture of the flexor muscles, and the appearance of a large slough at the site of the operation also appeared and endured. The patient succumbed three years afterward. At the autopsy the brain, the pons, and the medulla oblongata were found to have islets of degeneration; the cervical and dorsal segments of the cord were the seat of a diffuse degeneration, which attained its maximum in the middle part of the dorsal region; finally, the right half of the lumbar enlargement was sown through with numerous foci of degeneration, which Westphal considered as in all probability produced by the laceration resulting from the stretching of the right sciatic nerve. The weight of the authority makes the case worth recording in regard to the possible dangers of nerve-stretching.—*Gaillard's Medical Journal.*

A CASE OF OBSTRUCTION OF THE BOWELS, lasting eighteen days, was relieved by Dr. Botley (*Le Progres Medicale*) by means of electricity. Mme. H. aged 77, after a few days of constipation, was taken with complete obstruction, for the relief of which all ordinary methods were tried in vain, and the question of making an artificial anus was considered, as she daily became weaker with intense tympanites and stercoraceous vomiting. It was decided, however, to try electricity first. On the 17th day an induction current was used, one pole in the rectum the other over the bowels for fifteen minutes; in the evening slight colic was felt, indicating the return of action in the bowels. Next day another application of electricity was made, lasting only twelve minutes, on account of colicky pains produced by the current. A passage was effected the next morning, lasting two hours, consisting of at first hard masses, then soft, accompanied with intestinal gases.—*The Weekly Med. Review.*

PERNICIOUS ANÆMIA.—Prof Da Costa has had large experience with idiopathic (pernicious) anæmia. He has observed that pregnant women are most disposed to it. The cause of the disease is unknown; he has had cases with and without degeneration of the gastric tubules. He had noticed in the Pennsylvania Hospital, long before this fact was published by others, that a fever develops without other cause. This fever is apt to be of long continuance. The books give the duration of this disease as too short; the duration is several years, as a rule, though it may run a more rapid course in pregnant women. His belief in the

fatality of the prognosis is very strong, and he doubts the diagnosis in all the reported cures he has read of; but is much more hopeful than formerly concerning the probability of prolonging life. The greatest possible attention must be paid to obtaining a blood-making diet. Freshly-drawn bullock's blood is advantageous, where it is not too offensive to the patient. A sea voyage is of great benefit. Manganese is useless; iron in very large doses, of some value; and arsenic in small doses, long continued, has given him better results than any other remedy. In the later stage, when transfusion is bruited, he discourages it, for improvement from it is only very temporary.—*Col. and Clin. Rec.*

METHOD OF REMOVING NASAL POLYPI.—Dr. William Ralph Bell, *Can. Med. Record*, Feb. '84, says: "I take the liberty of bringing the mode of treatment before the notice of your readers, which I have practiced, with the very best results, in several cases. It obviates any trouble from hemorrhage, which is frequently the case when the forceps or hook is used; it is painless, and very simple. I get my patient to blow strongly through the affected nostril, closing the other with his finger. The polypus will be brought down so that it can be easily seen through the external nares; then with my hypodermic syringe charged with a solution of tannic acid in water (of the strength of twenty grains to the fluid drachm), I pierce the polypus with the needle, and inject ten, fifteen, or twenty minims of solution, according to size of tumor. In a few days the polypus shrivels and dries up (tanned); it comes away without any trouble or pain, and looks like a clot of dry blood, my patients usually removing it by blowing the nose, or by their fingers. In only one case, that of an old lady, had I occasion to remove it myself, and in her case I think she was afraid to do so, for when I seized it with dressing-forceps I was required to make no traction to bring it away."

Prof. Bartholow said, in a recent lecture, "Creasote is curative—I use the word advisedly—in a small proportion of cases of the more chronic form of tuberculosis, and decidedly ameliorative in the rest, being useless in tuberculosis florida." He vaporizes it with iodine, by means of hot water (120°), and the patient inhales the vapor slowly and deeply, from a distance of from fifteen to twenty-four inches from the vaporizer. Or gr. iij-v may be given in a pill with tolu, three or four times a day, the dose being gradually increased until the urine is darkened. It is most valuable in chronic cases before the stage of softening. Its action is its influence on the bacillus tuberculosis, the Professor said, and the physicians of the Montpellier (France) school find it to be better than carbolic acid, for consumption.

TO DESTROY THE ODOR OF IODOFORM.—Dr.

Louis Lewis, of Philadelphia, in the *Med. Bulletin* states that the intense odor of iodoform is almost destroyed by the admixture of oleate of zinc, in equal proportions. As the application of this preparation of zinc is suggested in many cases calling for the employment of iodoform (such as phagadenic ulceration, chancroid, etc.) I have ventured to call attention to the fact, more especially as iodoform is too irritating in many cases when used alone. The combination forms an excellent powder, soft and bland; and supplies its own moisture, in contact with the diseased surface, by virtue of the oleic acid.

SPLENECTOMY.—Mr. Knowsley Thornton removed a multilocular cystic spleen by abdominal section (median incision) at the Samaritan Hospital on Tuesday the 16th inst. The patient was a single girl, aged 19, and the tumor had been slowly growing for two years. Latterly it had increased much more rapidly, and caused considerable amount of pain. The patient is progressing satisfactorily. During the tying of the pedicle she suffered severely from shock, and for some minutes her life was in danger, but she revived directly the tumour was cut away, and the drag taken off the pedicle. The specimen will be shown and the further progress of the case reported at the Pathological Society.

SALICYLATE OF SODA IN PHLEGMASIA ALBA DOLENS.—D. Miguel Vigar (*La Correspondencia Medica*) says that of four cases of phlegmasia alba dolens which he has had occasion to treat, in the first with the topical remedies usually employed he obtained no result attributable to the medication, since the patient remained in bed two months; and that in the other three, having employed the salicylate of soda, in the dose of 4 grammes (60 grains) a day, he noticed in all, from the first day of taking the medicine, notable diminution of the fever and œdema. Neither of these patients passed more than twenty-one days in bed, and no œdema, nodosities, or thickening of the lower limb remained.—*Lond. Med. Record*.

THE ACTION OF QUININE UPON THE EAR.—Dr. Green (*Boston Med. and Surg. Journal* March 2, 1882) has an interesting and timely paper upon the above subject, and formulates his conclusions as follows: 1. Clinical experience the world over is, that quinine occasionally produces serious injury to the ears. 2. From our present knowledge, both clinical and experimental, we are justified in asserting that the action of quinine upon the ears is to produce congestion of the labyrinth and tympanum and sometimes distinct inflammation, with permanent tissue-changes. 3. The action of the drug upon the ears should always be considered in prescribing it, and changes in the ears, due to existing

or previous inflammation of those organs, constitute a contra-indication to the medicine in large doses or for a long time, except under urgent circumstances. 4. Where large and continuous doses are absolutely necessary, an occasional intermission of the administration is desirable, if possible, to diminish the risk to the ears.—*N. Y. Med. Four.*

CLEANLINESS IN SURGERY.—In an article on Operations for Myofibromata of the Uterus, Dr. Bigelow, speaking of the use of antiseptics says: "Perfect cleanliness is a preventive of decomposition, and its value can never be over-estimated. I myself believe that with a temperature in the operating room of 80° F., with plenty of hot water for instruments, sutures and appliances, with hands cleansed with ordinary brown soap, with a skilled operator and with a perfect observance of detail in cleansing the cavity, a good result will follow as certainly as if Listerism in any of its forms had been practised."

Prof. Da Costa considers the salicylates are not nearly as effective as salicylic acid in the treatment of rheumatism. If it does not do good in three or four days it becomes risky, and the plan of treatment should be changed. Prof. Bartholow finds the following more efficient than salicylate of sodium alone:—

R. Acid. salicylic ʒ ij
Sodi bicarb. ʒ j
Aquæ ʒ ij M.

SIG.—Dose, one to two teaspoonfuls.

A RELIABLE TÆNIAFUGE.—Mr. J. B. Lawson reports good results from this in the *Glasgow Med. Journal*, January, 1884:

R Extracti filicis maris ʒ iss
Pulveris kameleæ ʒ ij
Mucilaginis acaciæ
Syrupi simplicis, aa ʒ ij
Aquæ cinnamomi, ad ʒ iij

M. S. Half to be taken at bed-time, and the other half early in the morning.

Prof. Gross teaches that if the brain is penetrated by a ball, the rule to let it alone is an exceedingly bad one. Investigation has shown that the brain can be handled to a considerable extent with impunity, and there is a great future for operations within the cranial cavity, he says. Prof. Moses Gunn, of Chicago, leans toward the same opinion, in his lectures to his classes.—*Col. and Clin. Record.*

TEETHING—BROMIDE OF SODIUM.—A few grains dissolved in a tumblerful of water, so that each teaspoonful may represent a half grain, will quickly quiet the nervous disturbance of teething infants, or fever not dependent upon the onset of an in-

flammation or other grave trouble, but rather such as many follow excitement of any kind. The dose should be repeated every ten or fifteen minutes.—*Medical Summary.*

A NEW INJECTION FOR GONORRHOEA.—This sedative and antiseptic injection may be used even in the acute stage, with good results. It is claimed to be superior to any other single injection:

R Pulv. iodoformi, 20;
Acidi carbolici, 10;
Glycerini, 80;
Aquæ destillatæ, 200. M.

—*Campana.*

IODIDE OF POTASSIUM IN PSORIASIS.—Greve states (*Tidsskrift for praktisk Med.*) that psoriasis is always curable by large doses of iodide of potassium. He begins by small doses until the remedy is tolerated, and gradually increases the dose until he gives as much as thirty to forty-five grains. The curative effects are then evident.—*Practitioner.*

JENSEN'S CRYSTAL PEPSIN.—The knowledge of the value of this variety of pepsin is rapidly extending. Recently the United States Marine Hospital Service has ordered three kilos of it at once, to be put up in 2.5 gramme bottles. Dr. Jensen has devoted many years of close attention to perfecting his product, and it now stands with the very first in its line.

REMEDY FOR COMEDONES.—The remedy is acetic acid which is conveniently applied in the following way: Make an ointment of kaolin (potter's clay), four parts, glycerin, three parts, acetic acid, two parts. Cover the part affected in the evening; after several days most of them come out by washing with pumice soap.—*Am. J. Phar.*

Prof. Da Costa teaches that Addison's disease is not any indefinite affection of the supra-renal capsules, but a certain pathological process in them—a low grade of inflammation leading to cheesy degeneration. He, personally, has had best results from treatment with arsenic and cod-liver oil.

No case should be given up as an incurable in which only single remedies have been employed. It often happens that syphilitic patients who exhibit no kind of improvement under iodide of potassium will get rapidly well if submitted to the influence of mercury; and many other instances might be cited.—*Med. Press.*

Prof. Brinton says: "Corrosive sublimate is the coming antiseptic. I have always looked with a certain amount of disbelief on carbolic acid, but this idea of corrosive sublimate is one I can take hold of."

THE CANADA LANCET.

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PNEUMONIA AND VENESECTION.

Amongst the more common diseases it would be difficult to name one more sudden in its onset, or, at times, more rapidly fatal, than pneumonia. It must not, however, be inferred that we regard pneumonia as a peculiarly fatal disease. Considering its great prevalence and the vital importance of the organs chiefly involved, the wonder is that the death-rate is not greater than it is. At all times and under all circumstances, however, it is a grave disease, requiring all the care and skill at the command of the physician.

Universally regarded in the past as a purely inflammatory disease, pneumonia has now come to be regarded by many as a disease constitutional in character—zymotic in fact, having its own local lesions, like diphtheria with its membranous formation, or typhoid with its ulceration of Peyer's glands. In support of this view the following arguments are advanced: It is a disease of definite duration, generally ending by a crisis from the fifth to the ninth day, a thorough sweat being followed by mitigation of all the symptoms, ending in resolution. The fact that some cases linger beyond the usual time is only what happens in all diseases, and is therefore no argument against the new theory. Further, cases prove fatal with but a small amount of lung lesion, for example, involving no more than the lower lobe of one lung. In such cases the local lesion is held to be inadequate as a cause of death, and can only be regarded as secondary. In tubercular phthisis we meet with an immense amount of lung destruction, and yet the

patient often lives on for years in comparative comfort, thus showing that the impairment of a limited portion of lung by inflammation cannot alone be regarded as a cause of death. The chill at the onset of pneumonia, the subsequent high temperature, the cerebral symptoms often witnessed, as in typhoid, are considered additional reasons for classing pneumonia amongst the zymotic diseases. Whether this view be correct or not, one thing is certain, and that is, that we frequently meet cases where the constitutional disturbance is out of all proportion to the local lesion. In such cases, if not in all, the physician who has regard for the general system first, and the lung next, is more likely to be able to cope with the disease than he who regards the lung first and the general conditions after. Many valuable lives have been lost by placing the cart before the horse in the treatment of this disease.

Speculations regarding the cause and nature of pneumonia are highly interesting, no doubt, but of far greater moment to the physician is the question of treatment, and this brings us again on uncertain ground. Here, as in many other cases, modern advances in science avail us but little. Whether we like it or not, we are driven back to the well-worn lines of clinical experience; we have absolutely nothing else to guide us in the treatment of this disease. If we have improved on the treatment of former times (which some deny), we have done so because of a general advance all along the line, rather than by the discovery of anything new having special reference to the treatment of pneumonia. Twenty or thirty years ago Bennett and others imagined that they had discovered a new revelation when they found patients recovering who had not been bled. From this they concluded that bleeding was bad practice and should be shunned under all circumstances. Then followed what may be appropriately called the bloodless era in medicine, so bloodless indeed that thousands of physicians of our time have never opened a vein. After a time a few became bold enough to bleed in puerperal convulsions and some forms of cerebral troubles. More recently venesection in pneumonia and other acute diseases has been revived and strenuously advocated by many of the ablest men in the profession. Indeed, it is safe to add, that so complete is this reaction that but few intelligent physicians hold out as opponents of the

lancet under all circumstances. No one desires a return to the indiscriminate practice of venesection, but there is every evidence that it is now regarded by the profession as a valuable remedial agent, to be employed in all suitable cases, not merely in pneumonia but in other diseases as well, presenting the proper indications of course.

No one proposes to bleed simply because the patient has pneumonia or acute meningitis. If the pulse is weak and the system already reduced, the lancet is to be withheld. On the other hand, in the full-blooded, with a strong, corded pulse, all experience proves that the lancet is unequalled as a restorer of the balance of the vital forces. Dr. Atlee, late president of the American Medical Association, writes as follows: "In the early stage with a full, corded pulse, there is no substitute for the lancet. . . . In high febrile excitement it *unloads* the system, restores the suspended normal secretions, and awakens in it the dormant susceptibilities to the effects of our medicines. The fear of debility has caused the death of thousands. . . . I cannot believe that the loss of ten or twenty ounces of blood in the commencement of an acute disease—as, for instance, pneumonia, when the blood is driven into the delicate tissue of the lungs, already filled to repletion by the previous congestion; which loss will not only relieve the congestion, but lessen the reaction, by weakening the power of the heart—can produce as much real debility as the progress of the inflammation will do if we endeavor to control it by less decided and efficient remedies. It is disorganization and not real debility and exhaustion we have to fear. Some years ago the late Dr. Gross placed on record the following words: "In the course of lectures which I annually deliver in Jefferson Medical College, I dwelt with much force and emphasis upon the employment of the lancet in the early stages of inflammatory affections involving important structures before they have been overwhelmed by inflammatory exudation. I wish to God that it was in my power to write the sentence in letters of fire, upon the brain of every practising physician and surgeon in the civilized world." These are strong and weighty words coming from such eminent men as Drs. Atlee and Gross. It would be easy to quote other distinguished authority, in all lands, expressing similar sentiments. In fact all recent writers

of note strongly advocate the use of the lancet in acute inflammatory disease.

It is somewhat remarkable, in the face of such testimony, that venesection is so seldom practised. This may be due partly to the fact that the present generation of physicians matured their opinions at a time when their teachers stood in holy horror at the loss of blood, and believed in storing it up for the evil day to come. As then, so now, to use the terse words of Dr. Atlee, "the *fear of debility*" still haunts our imaginations and causes the sacrifice of many precious lives. The sudden deaths from pneumonia, so characteristic of the bloodless era, are due, in a large measure, to the "fear of debility" which prevents the "unloading of the system," so as to restore the suspended normal secretions, and awaken in it the dormant susceptibility to the effects of our medicines."

To be of service, blood-letting must be properly performed. The patient must be held in the sitting posture and bled until the approach of fainting, which requires the withdrawal of from ten to twenty ounces. Unless in the very robust, it is seldom advisable to repeat the operation a second time. After the fourth day it is generally held that venesection will do more harm than good in pneumonia. At the beginning of the disease is the golden hour, but we do not always see our patient then. When we do it is our duty to give him the benefit of this mode of treatment, provided the case is within the rules laid down for guidance.

LIBELLING BRITISH INSTITUTIONS

In a recent editorial in our contemporary of this city on the subject of some changes proposed in the curriculum of the Ontario Medical Council, the following gratuitous insinuations are made against the examining board of the Edinburgh College, although the writer has not the manliness to name the college in question. Happily the circulation of the journal in which the article appears is very limited, so that little harm will arise in consequence of any such random utterances as those quoted, of parties utterly uninformed on the subject on which they presume to speak *ex-cathedra*.

The following is the passage referred to:—"It is well to remember, at the same time, that the Council in its honest endeavours to raise the

standard of medical education is sadly handicapped by the procedures of a certain Examining Board, an institution which is a disgrace to the classic city of Edinburgh as well as the whole United Kingdom, which is apparently willing to accept and pass anything from this continent, when the sufficient number of guineas is at the same time forthcoming."

By way of reply we subjoin a few of the figures presented by Dr. Aquilla Smith, at the meeting of the British Medical Council held in London in March last. The figures given are the percentages of rejections of the principal English, Scottish, and Irish Examining Bodies during the year 1883. The Royal Colleges of Physicians and Surgeons of Edinburgh (conjoint examinations), rejections, 47 per cent.; the Royal College of Surgeons of Edinburgh, 47; the Faculty of Physicians of Glasgow, 43; the Royal College of Physicians of Edinburgh and the Faculty of Surgeons of Glasgow (conjoint), 42; the Royal College of Surgeons of England, 36; the Royal College of Physicians of London, 30; the Royal College of Physicians of Edinburgh, 29.3; the Royal College of Surgeons of Ireland, 25; the King and Queen's College of Physicians of Ireland, 22.

These figures speak for themselves, and show how high is the standing of the colleges so assailed—colleges whose qualifications, many of the best men of the profession, the civilized world over, wear with a pride not to be wondered at. The cause of our Ontario Medical Council, a body which has our warmest sympathy and respect, is not to be served, but rather the reverse, by such attacks on the honoured institutions in the motherland; and while we urge every Canadian student to take the Council examinations, we are very proud to see so many of them, after completing their studies here, going to Britain and returning home with well deserved and hard won honours.

THE AMERICAN MEDICAL ASSOCIATION.

The 35th annual meeting of the American Medical Association was held in Washington, on the 6th, 7th, 8th, and 9th ult., under the presidency of Prof. Austin Flint, Sr. The meeting was largely attended, there being upwards of 1,200 members present, and was one of the most successful in the history of the Association. The president's ad-

dress, as was to have been expected, was able and eloquent, and elicited favorable comment. One of its most important features was the reference to the subject of the code of ethics. He was disposed to put the most charitable construction upon that section of the code relating to consultation with irregular practitioners. He seemed to think there were circumstances in which the demands of humanity should take precedence of the written code. The whole tenor of his remarks on this subject, indicate that in his opinion some change in the present code will sooner or later have to be made. The thread-bare subject of medical education in the United States came in for a share of the president's attention. This has been for a long time a bone of contention, and the profession does not appear to be any nearer a solution of the difficulty than they were several years ago. The real solution is undoubtedly in the establishment of State examinations. It is impossible to expect any reform to come about in any other way, in the face of such a multiplicity of medical colleges as are to be found in the United States.

The work of the sessions was very well sustained. The address in Medicine was delivered by Dr. Shoemaker, of Philadelphia, and consisted of a resumé of the progress of medicine and new discoveries during the past year. The address in Obstetrics and Diseases of Women and Children was delivered by Dr. J. A. Reamy, of Cincinnati, O., in which he gave notes of 231 cases of laceration of the cervix uteri operated upon without a single death. The discussions on the various topics introduced were interesting and instructive, and nothing occurred to mar the harmony of the proceedings. A sudden gloom was cast over the Association at the close of the first day by the announcement of the death of Prof. Gross, of Philadelphia.

A formal invitation was tendered on behalf of the medical profession of the United States to the International Medical Congress to hold its next session in 1887, in the City of Washington. Various resolutions relating to public health and other matters of general interest were duly passed in the general sessions, for example, the Sanitary Regulations of Transatlantic Steamers, grant to the National Board of Health, appropriation to promote researches relating to the causes

and means of prevention of infectious diseases, etc. The Journal of the Association came in for a share of criticism, and although the exhibit was not very flattering, the feeling evinced upon the whole was to give it a trial for another year. Dr. H. F. Campbell, of Georgia, was elected President for the ensuing year, and New Orleans selected as the next place of meeting on the last Tuesday in April, 1885. The following gentlemen were appointed delegates to the Canada Medical Association, Drs. W. S. Tremaine, E. N. Bush, W. Brodie, and H. O. Walker.

ANÆSTHESIA BY THE RECTUM. — This new method of producing anæsthesia first suggested by Dr. Molliere of Lyons, has attracted considerable attention of late. The advantages of such a method in operations about the mouth and throat are certainly very great, rendering it possible to maintain anæsthesia without inconveniencing the operator. It also diminishes in most cases the stage of excitement, lessens the tendency to vomiting, and does away with the uncomfortable local effects following the contact of the vapor with the air passages. But while there are advantages there are also some objections to the method. Among the objections may be mentioned distension of the bowels by the vapor of ether, the tendency to the production of diarrhoea, and the difficulty of regulating the degree of anæsthesia, as there is no means of withdrawing the ether when once introduced into the bowel, and being continuously absorbed after anæsthesia has been already complete, there is danger of serious results. The quantity of ether required to produce anæsthesia by this method is very small, the average being about two ounces. The mode of administering it is as follows: Two ounces of ether are put into a bottle the mouth of which is connected by rubber tubing with the vaginal nozzle of a Davidson syringe, which is inserted into the rectum. The bottle containing the ether is then placed in a vessel of water of about 120°F. The ether boils and the vapor passes into the bowel. It is hardly necessary to say that the bowels should be well cleared out before proceeding to etherize by this method. It is not at all likely that the rectal method will supersede the ordinary way, but it is undoubtedly a valuable addition to it, and one that will prove most serviceable in certain cases.

CEMETRIES AND WAREHOUSE SUPPLY. — We have received a copy of the *Star and Herald* of Panama in which we find a very interesting letter by Dr. Wolfred Nelson, formerly of Montreal, on the above subject. From this we learn that the native cemeteries in Panama are in a most deplorable condition. Fully one-half of the dead are buried without coffins. Coffins are secured at a small rental for the funeral; at the grave the dead are taken out wrapped in a sheet and buried. The coffin is returned to the shop of the undertaker, in its turn to serve as a disease-producing factor. Owing to the smallness of the lot, in twelve months or less, the coffins, or bones, or both, as the case may be, are rudely disturbed to make way for "new arrivals" and are cast out of their temporary homes. Within that lot one sees scattered about coffins, pieces of coffins, bones, skulls, parts of clothing, etc., etc. For decency's sake they are gathered together occasionally, and burned, but what of the germs? This goes on under our intertropical sun, with an average yearly temperature of 84° in the shade. Can health be expected under such circumstances? These germs in millions are cast loose from what should be their final resting place, and fly abroad to cause new diseases and death. Surely there is great need of sanitary reform in such a community as this, and Dr. Nelson has certainly earned the thanks of the citizens for his efforts on their behalf.

MANITOBA MEDICAL COLLEGE. — The first session of the Manitoba Medical College was brought to a close by a grand dinner being given at the Douglass House, Winnipeg. About sixty invitations were issued and all the leading physicians in the city besides gentlemen connected with the educational interests of Manitoba were present. Few medical schools have been started under more favorable circumstances, not only as regards numbers in attendance, but also from the high educational status of the students generally. During the past session eighteen students have enrolled their names on the college register, and a number of applications of second year men from Ann Arbor Medical School Mich., also from the Toronto Schools of Medicine have been received, and there is every prospect of a very large attendance next session. The following are the professors and lecturers of the college: Dr. Kerr, Dean and Prof. of the princi-

ples and practice of surgery ; Dr. Jones, Prof. of principles and practice of medicine ; Dr. Blanchard, Prof. of anatomy ; Dr. Good, Prof. of clinical surgery ; Dr. Whiteford, Registrar and Prof. of clinical medicine ; Dr. A. H. Ferguson, Prof. of physiology ; Dr. Brett, Prof. of materia medica and therapeutics ; Dr. R. B. Ferguson, Prof. of obstetrics ; Dr. Sutherland, Prof. of medical jurisprudence ; Dr. Patterson, Prof. of hygiene and public health ; J. Fawcett, B. A., Prof. of chemistry ; Dr. McDiamid, Demonstrator of anatomy.

BEEF PEPTONIDS.—A recent improvement has been made in this valuable preparation by the manufacturers which consists in the addition of the solids of milk. It is composed of dry lean of beef, one-third ; solids of milk, one-third ; and gluten of wheat, one-third ; all of which are partially digested or peptonized. Prof. Atfield of London, Eng., has recently made a careful analysis of this preparation and states that it contains the substances named in the quantities above given, and that it is easily and wholly digested when taken into the stomach. He concludes his report as follows :—It is by far the most nutritious and concentrated food I have ever met with. Indeed, a palatable and assimilable and in every way acceptable article of food, containing nearly 70 per cent. of truly nutritive nitrogenous material partially peptonized has never before, to my knowledge, been offered to the medical profession or to the public. Dr. Stutzer of Bonn, who has also examined this preparation says that the results of his analyses are such as to enable him to pronounce beef peptonoids to be a *most valuable and easily digested* nitrogenous food for invalids and convalescents.

TORONTO UNIVERSITY EXAMINATIONS.—The following are the names of those who have passed the medical examinations at Toronto University, in the various years :—

FIRST YEAR.—Green, W. D. ; Reid, J. B. (*æq Scholarships*) ; Bremner, F. P. ; Drummond, H. E. ; Eastwood, J. H. ; Ege, A. ; Johnston, D. ; Keane, M. J. ; McMahon, J. A. ; Olmstead, I. ; Perfect, A. H. ; Stewart, W. O. ; Walters, W. R. ; Watson, W. R. ; Eadie, A. B. ; McKay, A. E. ; Thompson, A. B. ; Thornburn, J. D.

SECOND YEAR.—Peters, G. A. (*1st scholarship*) ; Johnston, D. R. (*2nd scholarship*) ; Bigelow, A. W. ; Carlyle, J. C. ; Caven, W. P. ; Greig, W. J. ; Ham-

ilton, H. J. ; Marty, J. ; McKenzie, D. ; Mustard, J. W. ; Noecker, C. T. ; Parker, S. G. ; Peaker, J. W. ; Weld, O. ; Little, H. E. R. ; Britton, C. H. ; Macoun, J.

THIRD YEAR.—Howel, J. H. (*1st scholarship*) ; Carr, L. (*2nd scholarship*) ; Bourke, D. ; Broadfoot, A. ; Cane, F. W. ; Carveith, G. H. ; Kinsley, A. B. ; Krick, C. A. ; Minchin, D. J. ; Webster, H. E. ; Saunders, M. R. ; Hoople, H. N. ; Staebler, D. M. ; Bascom, H. ; Cherry, G. A.

FINAL.—Clerke, J. W. (*Gold Medallist*) ; Johnston, J. ; McKenzie, A. F. ; Patterson, J. W. ; Spence, J. ; Stewart, S. ; Stewart, R. L. ; Bray, J. ; Draper, J. S. ; Bingham, G. A. ; Knill, E. G.

POWDERED EXTRACTS.—A full list of powdered extracts is much needed. These, pharmacy can and ought to provide. For the druggist they are almost as convenient as fluids, while for the country physician they are infinitely more so. They are soluble in water and other fluids and hence are available for mixtures. Indeed when we consider their merits, the wonder is that the extracts have not been called into more extensive use. Of late years they have been coming into favor in the United States, especially in that section having Chicago for its centre. One manufacturing firm, at least, in that city, makes a specialty of powdered extracts. The Canadian manufacturing chemist who first occupies this field, and places his preparations prominently before the profession, is certain to be rewarded for his enterprise.

MENTHOL POINTS.—This new remedy for neuralgia, etc., which we noticed in the April number of the LANCET under the head of "Neuralgia Pencils," has been introduced to the medical profession in this city by Mr. Robinson, chemist. Menthol, the crystallized camphor of Japanese oil of peppermint, is applied locally, and for its more convenient use is formed into small cone-shaped pencils mounted in boxwood handles, similar to nitrate of silver pencils. The mode of application is to gently rub the point over the painful part, when a slight prickling impression of burning will be produced, followed in the course of one or two minutes by a pleasantly cool sensation, and an entire alleviation of the pain.

PACKER'S TAR SOAP.—This excellent soap has now been before the profession for some time, and its merits have been thoroughly tested. There is none in the market equal to it for use in skin dis-

eases, especially where tar is indicated in the treatment, as for example in eczema, herpes, erythema, etc. We were led to make use of it from the very high recommendation given to it by Dr. Bulkley of New York, Dr. Mundè, and others, and our experience of its use in practice has been very gratifying. It is an excellent deodorizer and disinfectant.

HONOR TO WHOM, ETC.—The following distinguished members of the medical profession received the degree of LL.D. from the University of Edinburgh at the recent tercentenary celebration:—Fordyce Barker, S. D. Gross, J. S. Billings, Sir W. Bowman, Sir Andrew Clark, Cheveau, (Lyons), Erichsen, Sir W. Gull, Haeckel, Dr. Haldane, Halle, Houghton, (Dublin), VonHelmholtz, Jenner, Keith, Marshall, Maudesley, Paget, Pasteur, Pettinkoffer, Priestley, Rawlinson, Schmidsberg, Smith, Stokvis, P. H. Watson, (Edin.) Virchow, and Wilks.

QUEBRACHO IN ASTHMA.—This drug has been for some time before the profession as a remedy for asthma. Prof. DaCosta, of Philadelphia, has had very satisfactory results from its use in dyspnœa, and states that it has been especially serviceable in two classes of cases. 1. In purely nervous asthma. 2. In cases in which a heart lesion has produced failure of cardiac contraction, and consequent congestion of the lungs. He thinks it must be regarded either as a heart tonic, or a nervine to the respiratory centre. The dose is twenty minims of the fluid extract every hour, until relief is obtained, when it is given at longer intervals.

MALPRACTICE SUIT.—We are pleased to learn that Dr. Arnott, of London, was successful in the suit for malpractice brought against him by a patient named Ingraham. The case was one of dislocation of the ankle with fracture, and was treated by a plaster of Paris splint, but the patient was dissatisfied with the result, and hence the action. It was shown by the defence that the treatment was most judicious, and that the bad results were due entirely to want of care and necessary rest of the injured limb on the part of the patient. We congratulate the doctor on the result.

APPOINTMENTS.—Dr. V. H. Moore, of Brockville, has been chosen representative of Queen's University, Kingston, on the Ontario Medical

Council, *vice* Dr. McCammon, resigned, owing to his having accepted a Professorship in the Kingston Medical School. Dr. D'Orsonnens, President of the Victoria Medical School, Montreal, has been appointed to the chair of Obstetrics, *vice* Dr. Trudel, deceased. Dr. A. W. Cogswell has been appointed House Surgeon to the Halifax Hospital, *vice* Dr. Smith, resigned.

HALIFAX MEDICAL COLLEGE.—The following gentlemen have passed their professional examinations. The total number of students in attendance during the past session was 35:

M. D. C. M.—J. W. Reid (Faculty prize), A. W. Cogswell, J. Weir, J. M. Gourley, J. McKenzie.

PRIMARY.—A. J. Fuller, J. W. N. Baker, A. J. Murray. D. Murray and D. McLeod passed in all branches but physiology.

ONTARIO BOARD OF HEALTH.—We have much pleasure in announcing that Dr. C. W. Covernton of this city has been appointed Chairman of the Ontario Board of Health. The appointment is a good one, and cannot fail to give satisfaction to the medical profession of Ontario. The retiring members have been re-appointed, and Dr. Bryce, Secretary, has been appointed a member of the Board.

ONTARIO MEDICAL COUNCIL MATRICULATION.—The regulations recently issued by the Minister of Education, Ontario, contain a paragraph defining the examination required by candidates for the matriculation of the College of Physicians and Surgeons of Ontario. The subjects named are those decided upon by the Medical Council some years ago, viz.: English grammar, literature and composition, dictation, arithmetic, algebra, euclid, history, geography and Latin.

CORROSIVE SUBLIMATE IN DIPHTHERIA AND CROUP.—In the *N. Y. Med. Journal*, April 19th, '84, Dr. Thallon, of Brooklyn, has an article on the treatment of diphtheria and croup by the internal administration of bichloride of mercury. The dose is from one-tenth to one grain during the twenty-four hours. Other drugs, as alcohol, opium, quinine, are to be used when indicated. He claims excellent results in his own practice, as well as in that of Dr. Skene, since adopting this plan of treatment.

BISHOPS MEDICAL COLLEGE, MONTREAL.—The following are the names of the successful candidates in medicine :

PRIMARY:—F. R. England, (David Scholarship); C. E. Parent, S. Riopel, W. G. Nichol, E. O. Laferrriere and J. F. Gore.

M. D., C. M. :—E. E. Bronstorff, (Wood and Nelson, gold medals), R. C. Blackmer, (Chancellor's prize), C. D. Ball, S. Riopel, C. A. Lafontaine, W. Patterson, W. H. Drummond, W. A. Mackay, J. F. Gore and J. Oglivie.

REMEDY FOR DYSPEPSIA.—The following excellent prescription for dyspepsia is given by Dr. Alfonso in the *Medical and Surgical Reporter* :

R Pepsin (Jensen's).....3iij.
Acid Tartgrs. v.
Glycerine3iss.
Vini Xerici.....3vjss.

Sig.—A teaspoonful after meals.

DEATH OF PROFS. GROSS AND PARKER.—All our American exchanges contain full obituary notices of the late Profs. S. W. Gross, of Philadelphia, and Willard Parker, of New York. Prof. Gross was in his 79th year and Parker in his 84th. The remains of Prof. Gross were cremated.

MILITARY.—Dr. J. W. Lesslie, has been appointed Surgeon to the Queen's Own Rifles of Canada, *vice* Dr. F. W. Strange, transferred to the Infantry School corps, and Dr. J. Nattress, Assistant-Surgeon.

PARLIAMENTARY.—We are pleased to learn that Dr. Wilson, who was recently appointed Provincial Secretary of Manitoba, has been elected for South Dufferin by acclamation.

CORONER.—Dr. J. A. McDonell of Thunder Bay has been appointed Coroner for the District of Algoma. David Rose, M.D., of Waterford, has been appointed Coroner for the County of Norfolk.

Geo. Colquhoun, M.D., of Iroquois, has been appointed Coroner for the Counties of Stormont, Dundas and Glengarry.

PERSONAL.—Dr. Geo. Nelson of the Central Hospital at Huerta Galla, Panama, has gone to Santa Barbara, California, for the benefit of his health.

BRITISH DIPLOMA.—Dr. Wm. Anglin of Kingston has obtained the M.R.C.S., Eng.

Books and Pamphlets.

"SHAKESPEARE AS A PHYSICIAN." By J. Portman Chesney, M. D., of St. Joseph, Mo. Published by J. H. Chambers & Co., St. Louis.

This work which consists of about 200 pages, is a handsome volume, alike interesting and unique in its way, and will be highly prized by all lovers of Shakesperian literature. It is divided into nine chapters, one on each of the following subjects : obstetrics, psychology, neurology, pharmacology, etiology, dermatology, organology, chirurgery, and miscellaneous, and contains sixteen illustrations. The work also contains many useful and valuable lessons and suggestions relating to medicine, among the comments by the author. We regret, however to find the work marred by several inelegant expressions, such as the use of the modern and decidedly vulgar word "mash," which is anything but Shakesperian, and not at all in keeping with the text. Again the author seems too ready to obtrude his materialistic views upon his readers, and gives another pretext for the frequent insinuation that the medical profession is tainted with materialism. In commenting upon the following line (p 92), "And his pure brain (which some suppose the soul's frail dwelling-house") the author says : "We see nothing in man—no trait or attribute which answers to the principle of what people call "soul" except the attribute mind. As to the *immortality* of that manifestation I think the *motion* of my arm just as probable of everlasting preservation."

ELEMENTS OF PHARMACY, MATERIA MEDICA, AND THERAPEUTICS. By Wm. Whitla, M. D. Belfast, with lithographs and wood-cuts. Second edition. London : Henry Renshaw, 356 Strand.

Only a short time ago we noticed the first edition of this excellent little work. The rapid exhaustion of a very large issue of the first edition speaks well for the popularity of the work, and must be very gratifying to the author. The present edition has been carefully revised, and brought up to present date. The alphabetical and sectional way in which the work is divided seems to meet with general approval. Ample space is devoted to Pharmacy, and there is also added a description of all new remedies of note recently introduced. We especially commend the work to the attention of students as

a most admirable condensation of the subjects of which it treats. The small size of the book renders it most convenient for consultation by the student and busy practitioner.

A SACHEL GUIDE FOR THE VACATION TOURIST IN EUROPE, with Maps, including an admirable Route Map. 16mo. roan, flexible, \$1.50. New (13th) edition. Houghton, Mifflin & Co., Boston, Mass.

This is the best and most compact European guide-book we know of. It includes the British Isles, Belgium, Holland, Germany and the Rhine, Switzerland, France, Austria and Italy, and gives the traveller just the information he most needs in the most convenient form. We used a former edition of this work in our European travels in 1878, and found it brief, accurate and complete in every respect, and are much pleased to receive the present edition, which we hope to utilize in our travels this summer.

OPERA MINORA. A collection of Essays, Articles, Lectures and Addresses, from 1866 to 1862. By E. C. Seguin, M. D., New York. G. P. Putnam's Sons. Price \$4.50.

The subject of these papers relates chiefly to nervous diseases, but is not the less interesting and important on that account. The collection numbers about one hundred articles, each of which is written in an interesting style and contains the fullest information on the subject in hand. The therapeutics of the diseases treated of receives a fair share of attention. We commend the work to the attention of our readers.

ELEMENTARY PRINCIPLES OF ELECTRO-THERAPEUTICS, for the use of Physicians and Students, pp 420, with 125 illustrations. By C. M. Haynes, M.D. Chicago: McIntosh Galvanic and Faradic Battery Co. Price, \$2.

The author sets out by giving a brief history of electricity. The work is then divided into eleven chapters, and deals with all forms of electricity and its application in the cure of disease. That portion of the work dealing with electro-physiology and electro-therapeutics is especially interesting. It is presented as an elementary treatise on the subject, and will be of especial value to students and those who are introducing electricity as a therapeutic agent into their practice.

"MEDICAL ETHICS." By Frank H. Hamilton, M.D. New York: Bermingham & Co.

This is a very neat little volume of 129 pages, consisting of a series of conversations between Drs. Warren and Putnam, on the subject of medical ethics, with an account of the medical empiricisms of Europe and America. Two letters, one by Dr. Warren, referring to the medical empiricisms of Europe, and the other from Dr. Putnam, suggesting certain amendments to the National Code, will be found of special value to those who are interested in the code question.

The Physician's combined Day-Book and Ledger, by H. T. Hanks, M. D., New York. J. H. Vail & Co., Publishers, New York.

This is claimed to be the most exact and labor-saving system of book-keeping ever devised for the use of a physician. No separate day-book or posting is required, and to those who keep their own books it will be found exceedingly convenient. The work is most ingeniously devised, concise and compact, yet simple and easily understood. We commend it to the attention of the profession.

ELEMENTS OF SURGICAL PATHOLOGY, by Augustus J. Pepper, M. B., Lon., F. R. C. S., Eng., &c. Illustrated with eighty-one engravings. Philadelphia: H. C. Lea's, Son & Co. Toronto: Hart & Co.

In this little octavo volume of five hundred pages will be found a very complete epitome of surgical pathology. The work is clear, concise and well suited to the requirements of medical students.

THE MEDICAL DIRECTORY of Philadelphia, for 1884. By S. B. Hopkins, M.D. Philadelphia: P. Blakiston & Son.

Births, Marriages and Deaths.

In Paris, on April 28th, S. W. Cooke, M. D., in his 69th year.

In St. Paul, Minn., on the 10th ult., Dr. Kittson, aged 35 years.

At Cornwall, Ont., on the 10th ult., Dr. J. J. Dickinson, aged 65 years.

**** The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

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Original Communications.

GLIMPSES OF TRANSATLANTIC SURGERY.*

BY J. P. BROWN, M.D., L.R.C.S.E., GALT, ONT

GENTLEMEN :—Perhaps it would not be uninteresting while dealing with subjects with which all are familiar to touch lightly upon observations taken at the hospitals of England and Scotland only a year ago, and it is but just before commencing to remark upon the increasing number of graduates of our Canadian Universities, who find it to their advantage year by year to spend a season or more in the time-honored institutions of our mother-land. We, as Canadians, are proud of the position which our colleges occupy, and of the honors and other marks of distinction conferred upon our students when abroad ; yet, we cannot but feel and confess that these old centres of civilization with their crowded populations, their long trained and tried men, their accumulated lore and experience of centuries, open up to us a deeper and a wider field for research, and offer a more thorough knowledge of the art and science of our profession than we can possibly obtain in as limited a time in our own land. Hence it cannot but be a sound policy for our men after obtaining a theoretical training at our own schools, than which few can afford better, combined with all the practical information which our hospitals can give to finish off and prepare themselves for practical life by a season or two abroad. True, I did not follow this course myself, but allowed fifteen years to elapse after graduation before putting the plan into execution, but on the principle of "better late than never," the few months spent in hospitals abroad, will ever be remembered as a bright and profitable period, as well as a happy break in the ordinary routine of regular practice.

My first visit was to Old Edinboro' with its

classic beauty—its halls of learning—its monuments of Art—and to me, above all, its immense complex but complete Royal Infirmary. I will not describe the building, but when I say it is admirably situated, with good drainage, beautiful surroundings, and composed of an elaborate succession of buildings, all well lighted, well ventilated, and connected together by wide covered corridors, I have said enough. It is the only hospital in Edinboro, and is consequently systematically arranged for the admission of persons of all ages, and both sexes when suffering from disease or injury, or otherwise requiring professional skill. The staff of professors and teachers is composed of good men—the majority of them young or in the prime of life, many of them eminent, either as physicians or surgeons, and their clinical lectures in almost every case were clear, logical, searching expositions of the subject matter in hand.

Joseph Bell is among the most uncompromising of the disciples of Lister ; and his many operations that I witnessed, with the exception of one, were all performed under spray. He removed a number of breasts for scirrhus, and the treatment in each case was very similar to the preceding one. After producing anæsthesia, the carbolic spray was turned on—the instruments, sponges, &c., all being taken out of trays containing a one to forty solution of carbolic acid. The incisions were often elliptical ; cat-gut ligatures were invariably used ; also a long drainage tube which appeared to me of unnecessary thickness ; the usual sutures, but no plaster straps ; small oil silk protective placed over the line of union, covered by heavy layers of gauze, the lower ones being soaked in weak disinfectant solution. The cases were allowed to stand over for two days and then dressed daily under spray, the arm being bound each time almost invariably to the side. Although the cases differed much, they all did well. The union was generally rapid, and I was informed that frequently many years would elapse without a recurrence of cancer.

The exceptional case that I mentioned was one of extensive necrosis of the tibia. He refrained from using the spray on account of the deep-seated and wide-spread suppuration. This seemed like a strange argument to be used by an advocate of Listerism. He laid the leg open for two-thirds the length of the tibia, and with hammer and chisel, cut through the sound bone to reach the sequestra.

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These being removed, the several dressings of silk and carbolized gauze were applied. The dressing under spray was repeated on the third day, and at intervals subsequently the patient making a rapid recovery.

Prof. Annandale, who ranks high in the estimation of Scotch University men, had one remarkable case which made quite an impression at the time. He cut down through the mesial line upon the prostate in search of a supposed tumor but found instead a completely encysted stone an inch and a quarter in diameter, imbedded in the prostate. He extracted it with the cyst. The operation caused great hemorrhage. This continued with so much severity, that half an hour subsequent to the completion of operation, the drainage tube was taken out and the wound plugged with silk carbolized. In a few hours hemorrhage ceased, the tube was returned, and the patient, I believe, made a good recovery.

Genu-valgus, or Knock-knee, is common among the lower classes in the British Isles, and the operation for the deformity so frequent, that I may be pardoned for describing one of Prof. Annandale's cases. The child, female, 8 years old, was anæsthetized, and both limbs operated upon. A longitudinal incision in front and to inner side and parallel to lower third of femur was made, and wound held open by traction hooks. This was followed by a cross incision through the periosteum a little above the inner condyle and the bone itself cut almost through at the same site with hammer and chisel. The balance of the bone was broken by force, and the other limb being treated in like manner, they were each in turn straightened and fastened to the arms of a frame splint, the arms passing upwards on the outside of the limbs and were united by a cross-bar below the feet. No spray was used but carbolic oil—one to ten—was dropped on the wound from a syringe used for the purpose.

Among the most deeply interesting of operations was one performed by Mr. John Duncan, for obstruction of the bowels of a chronic character, upon a woman over fifty years of age. Five years previously she had suffered severely from abscess of the right iliac fossa; this had opened externally and I understood the operator to say into the bowel also. This fistula remained open for some time and finally closed, from which period the patient began

to suffer from obstruction. Fecal discharges were always small and watery and accompanied by pain. Sometimes obstruction became complete for a week or ten days with much vomiting, not unmingled with stercoraceous matter. During these periods life would be sustained by enemata of milk and beef-tea. Slight natural evacuations would again occur, and by careful dieting and copious injections the patient would enjoy a sufferable existence for several months again until the old symptoms would return. Each time the attack of complete obstruction became more alarming until finally Prof. Duncan decided to operate. So important and interesting was the case generally considered that a full staff of professors and lecturers, besides a large number of outside members of the profession gathered with the students in the principal operating theatre at the appointed time. Anæsthesia being complete, Mr. Duncan excised the old scar, and then carefully dissected through the adhesions down to the intestine. The first incision was parallel to Poupart's ligament. From this a little internal to the centre of it, another was made directly upwards. The flaps were deflected and the intestine reached. The affected portion was found, and was with much difficulty separated from its adhesions. The diagnosis was fully confirmed. The affected intestine was of a dark red congested color, and its calibre very much diminished. On examining it afterwards it would barely admit of the insertion of a pen-holder. Having extracted a sufficient amount of the intestine external to the abdomen so as to secure facility for completion of the operation, sound portions of the bowel above and below the stricture were fastened together by silk suture behind. Then the anterior and lateral portions of the upper gut were stitched to the upper portion of the intended artificial anus of the abdominal wall, and the anterior and lateral portions of the lower gut fastened by suture in like manner to the integuments above Poupart's ligament. The wound then being closed as much as possible, the bowel itself was excised to the extent of about three inches, the two segments thus together forming the artificial anus. The operation lasted one hour and-a-half, during which time the patient was completely under the influence of chloroform; and as the hemorrhage was very free, and the patient herself much emaciated, many expected that she would hardly survive the operation. She rallied,

however, very well, and Mr. Duncan, in his subsequent address stated that, if this primary operation proved successful, he intended, in due time, to perform a plastic operation, closing up the artificial anus and thus restoring the natural one to its normal use. Spray was not used in this case, Mr. Duncan being as strong an opponent, as Mr. Bell was an advocate of its utility. The dressings, however, were of the usual antiseptic character. Patient passed a good night, and reported herself as freer from pain on the following morning than she had been for months. I did not hear the subsequent history of the case.

On my last visit to Edinboro Infirmary I saw a patient suffering from one of those unfortunate accidents which sometimes occur even in the hands of the best surgeons. It was a case of empyema in a strongly built man of about thirty years of age. Paracentesis had been successfully performed a week previously, and a rubber drainage tube inserted; several pints of pus were discharged. From that time the drainage had been constant. One dressing had been made since under spray. But on approaching the bed on this occasion we found the poor fellow suffering very acutely. His lips were purple; he was propped up in bed and laboring under the severest dyspnoea. The surgeon was alarmed by his unexpected appearance, and immediately removed the dressings under the spray as before; but the discharge was very slight, and no drainage tube could be found. It slipped inside the pleural cavity, and by its presence there undoubtedly caused all the distress and general symptoms of collapse which we witnessed. The surgeon made many efforts to find it. He enlarged the wound, passed his forefinger deep within the chest, used forceps of different shapes, tried exploring sounds, and various positions of the body, with no effect but to increase the agony of the sufferer. The dressings were put on again and we left the ward sadder and perhaps wiser than when we entered. How long the poor fellow lasted I did not hear.

With regard to these drainage tubes I may mention that the usual way of securing them is to pass a couple of strong sutures through the external end and then to secure them firmly to the limb or body before applying the dressings. I was speaking of this case to the House Surgeon of the Children's Hospital, in Hackney, London, some weeks later.

He remarked that they always found difficulty in securing the tubes so as to avoid the possibility of accident; and that he had devised a method which secured perfect safety. He showed me the arrangement, and also two in actual use there. The end of the tube was split in quarter segments longitudinally. A circular rubber cap was then made with a hole in the centre large enough to admit the tube. The ends were passed through, and by the application of heat welded on to the upper surface of the cap. The cap would thus effectually prevent the possibility of slipping in so much dreaded.

As the surgical cases, methods of operation and general treatment were very similar in the various hospitals of London to what they were in Edinboro; I will not dwell on them, but pass on to notes taken upon several ovariectomy cases at the Samaritan Hospital at the west end. The building is not large, being simply one of a row of good sized three storey houses, supplied with a rear entrance for patients and a front one for the medical staff and visitors. The lower flat is devoted to offices, visitors' room, and out-patient department, where a very large number of women are treated daily. The ovariectomy rooms are on the highest floor and hundreds of operations are performed there every year by Sir Spencer Wells, Mr. Thornton, Mr. Bantock and others. Sir Spencer Wells and Mr. Thornton both use carbolic spray, and the Lister treatment in full, while Mr. Bantock, like Dr. Keith, of Edinboro', has entirely discarded the former while adhering to the latter on general principles. I saw two of Wells' cases. They both made excellent and rapid recoveries. I might describe Mr. Thornton's method of operating, as I had the good fortune to witness two of his operations on succeeding days. In each the fullest preparations were made. The room was scrupulously clean—ventilation perfect—instruments and sponges all placed in trays containing carbolic solution one to forty in strength. The hands of the operator and all his assistants, nurse included, were washed in like preparation. None others were allowed even to touch the patient or any of the instruments, sponges, &c., employed in the operation. In each case spray was used. The sponges, of which there were a large number, were wrung out and counted by the nurse upon the order of the operator before commencing—patient was put under chloroform—extremities covered warmly—abdomen exposed

and covered by rubber cloth, containing oval aperture, and held tightly down.

The incision in each case was between four and five inches long, extending from an inch below the umbilicus in the mesial line toward the pubes. After cutting through the abdominal wall, a tapping instrument with rubber tubing attached was plunged into the cyst, and the fluid drained into a vessel beneath. The cyst-walls were then gradually extracted, the adhesions being broken down by the fingers or handle of scalpel, the blade being used very little—numerous artery forceps were employed and allowed to remain suspended until the close of operation—torsion in many cases doing away with the necessity for ligatures. The large arteries were all ligated with cat-gut. The pedicle in each case was secured by a strong double silk ligature passed through its centre, then divided, each half being tied by its own half of the ligature. These were cut near to the knot. The pedicle being cut short was returned into the abdomen. Great pains were used to perfectly stop the hemorrhage before closing the abdomen. Finally, by a free use of sponges the oozing ceased. The nurse was again ordered to count the sponges while the external wound was being closed with interrupted sutures. In neither case was a drainage tube used. Dry lint was placed over the surface and long strips of adhesive plaster laid laterally over the abdomen. The patient was then removed to a bed in the same room, and shortly after returning to consciousness a dose of opium administered. The lightest diet was ordered for several days. An enema after three or four days and no dressing of abdomen for a week.

Mr. Bantock's operations, which resembled very much those of Mr. Thornton, with the single exception that spray was not employed, were all equally successful in the end. He had one rather peculiar case that created a good deal of interest. A woman aged about forty had an immense abdomen. He and several other physicians had, at different times, examined her very carefully. They could not, however, be sure in diagnosis, and so he announced to the class that as the case was doubtful he would make an exploratory incision. He made all the preparations for ovariectomy if necessary, and then making a straight linear incision in the mesial line for three or four inches, introduced a director and cut through the peri-

toneum. As a result there was an immense discharge of light straw-colored fluid; the case being one of peritoneal dropsy. Numerous adhesions had been formed between the gall-bladder, liver and intestines and granulations were present everywhere. The case was dressed like one of ordinary ovariectomy and made a good recovery, though in all probability the dropsy would not be long in returning.

Before leaving this subject I may mention that prior to leaving Edinboro' I had a long conversation with Dr. Keith. He has the reputation of being the most successful ovariectomist in the world. In recounting his experience he stated that some years ago he performed six operations within a few days of each other. He used the spray in every case. They were all what he considered average cases, and he performed the operations in his ovariectomy ward at the Royal Infirmary. Three out of the six died being a mortality of fifty per cent. This shook his faith in the efficacy of spray protective, and he determined to perform his next six without it although in other respects using antiseptic routine. The result was most gratifying and consequently he continued the practice. Out of the last fifty-one cases, although all spray had been discarded, he had lost but one, or barely two per cent., the lowest percentage on record. This result has had the effect of thoroughly establishing his views. Dr. Keith claimed that there were three valid objections to the use of carbolic spray in ovariectomy. 1st. The constant throwing of spray over the abdomen of the woman for the length of time required to perform the operation, had the effect of thoroughly chilling the system, and acting as a vital depressant. 2nd. The amount of carbolic acid absorbed was sufficient to have a seriously sedative or poisonous effect. 3rd. The spray obscured the parts operated upon, and consequently rendered the operation itself somewhat more difficult and dangerous. One would imagine that Dr. Keith's objection's are hardly entitled to the weight which he gives them, when we remember that Sir Spencer Wells, with his habitual use of the spray, loses barely four per cent.

It seems strange to find in the regular surgical staff of any large hospital such a diversity of views entertained by the leading men. One would judge however, that extreme Listerism is on the wane. And why should it not be? when men who have

discarded it are equally successful with those who sedulously follow its rigid routine. In obedience to the germ theory and Listerism combined we are directed to open abscesses, only under the protective influence of the spray: yet as I said before, Prof. Bell, the strongest supporter of the practice at the Edinboro' Royal Infirmary discarded it in his case of necrosis of the tibia, on account of the extensive suppuration existing, and yet in what essential points did this differ from an abscess?

Before closing I would like to say a word or two with regard to the administration of chloroform, of which I saw several hundred cases, in none of which was there any evil result. In Edinboro' a handkerchief or napkin was usually doubled or twisted to suit the fancy of the administrator. A drachm or two was placed upon it and renewed as occasion required. One operator folded his napkin in a small rectangular form, poured the chloroform on one side and placing the edge of the cloth on the chin just below the lip, held it at right angles to the face. The mouth and nose thus remained uncovered. His theory was, that the vapor of chloroform, being so much heavier than the air, would not rise, but be drawn in with each inspiration. The patients usually went quietly under the influence of the anæsthetic. There was very little opposition to its administration, and they were kept quite unconscious until the operation was over.

At the London Hospital which has nearly 800 beds, and at which a very large surgical practice is done, it is the almost universal custom to administer chloroform through an inhaler. The amount required is thrown into the instrument—which is then clapped tightly over the face—while the assistants hold the fortunate or unfortunate victim. The result is that in almost every case there is at the commencement a somewhat violent struggle. The patient cries for air, says he is choking, suffocating, etc., but the only effect is that the apparatus is held if anything a little more closely until the patient gradually becomes unconscious and ceases his struggles. In my inexperience in this method of producing anæsthesia, I was constantly afraid that some poor fellow would succumb, ere the surgeon's knife performed its important duty; but I am happy to say no such unfortunate casualty occurred. Still my impression with regard to an inhaler was not at all favorable—and I fancy it will be a long

time ere I add one to my ordinary armamentarium.

As a rule the hospitals in London and Edinboro'—particularly the Royal Infirmary at the latter place—are admirably kept. The wards are scrupulously clean. The ventilation systematically attended to—while each hospital has its full complement of trained and efficient nurses. The ladies there take a lively interest in these noble works of charity, and regularly supply them with hampers of choice flowers, very many of these being presents from the conservatories of the wealthy. These are divided up into bouquets and clusters and placed at regular intervals once or twice a week throughout the wards, cheering the thousands of sufferers by their beauty and fragrance. The physicians and surgeons are among the best of men—large-hearted noble fellows—who take a genuine pride and pleasure in doing all they can to alleviate the sufferings of the unfortunate class of people committed to their care. And filled as the hospitals are by sufferers from the lower walks of life, many of them constantly living from hand to mouth, and barely scraping together the necessities for existence, it is little wonder that they often look back to the days or weeks spent in the hospital or infirmary as among the happiest of their lives.

REPORT ON ASIATIC CHOLERA IN CALCUTTA, BY PROFESSOR KOCH.

Translated from *Uniao Medica*, Rio de Janeiro, by JOSEPH WORKMAN, M.D., Toronto, Ont.

As a complement to my report of the 16th of December last, on the labours of the Commission on Cholera in Calcutta, I have now the honour of transmitting to your Excellency the following information:—

The Commission has every reason to be gratified with the efficient concurrence and the sympathetic support awarded by the local authorities and the chiefs of hospitals.

We were permitted to examine almost all the bodies of those dying of cholera in the city hospitals allowed to be opened. Up to the present time we have made note of the materials furnished by nine autopsies, and eight patients under cholera.

As these cases occurred at equal intervals, we had sufficient time for the continuation of our investigations with all care. Various cases which

ended in death, after a short course, and without presenting any other complication of a pathological nature, afforded us opportunities for making important observations. From these favourable circumstances the Commission was enabled to give much advancement to the solution of the problem.

We must first of all say, that from the microscopic analysis we were able to discover, in the intestines of choleric, the same bacilli which we had before discovered in Egypt. In my report of 17th December last, I left provisionally undecided the question whether these bacilli, like other bacteria, belong to the number of the habitual parasites of the human intestine, or are, under the exclusive influence of the pathological process of cholera, developed in the intestinal mucus. Up to this time many characteristics which should have enabled us to distinguish these bacilli from other similar microbes, were wanting. Fortunately this want has now been met, thanks to the methods employed in the Hygienic Institute, which in this particular afforded valuable service, we have been able to isolate the bacilli coming from the intestines of choleric, and to cultivate them in pure media. A rigorous observance of the bacilli developed in cultures of complete purity, has led us to discover certain properties which are very characteristic, relative to the form and the growth of these bacilli in nutritive gelatine, so as to render it possible to distinguish them perfectly from other bacilli.

We have now no difficulty in answering the question whether the bacilli exist habitually in the intestines, or are met with only in the intestines of choleric.

In the first place, by means of cultures made in gelatine, we succeeded in discovering the bacilli, not only in the dejections of choleric, but also in the intestinal contents of the choleric cadavers. This result was constant in all the cases examined by us. We proceeded to examine the intestinal contents of other cadavers, and found that the bacillus did not exist in them. Until the present, eight cadavers of persons who died of different diseases, (pneumonia, dysentery, phthisis, and kidney disease), have been examined by us. Lastly we have examined the intestinal contents of different animals and substances rich in bacteria, and so far we have not met with a single bacillus resembling that of cholera.

If in the future these facts shall prove constant, we shall have achieved a very important result. In fact, if these bacilli, endowed with specific properties, pertain exclusively to the cholera process, it will no longer be legitimate to doubt that an etiological relation exists between their presence and cholera, even when trials to reproduce the disease in animals prove abortive. But here also, the conditions appear to be very favorable, as some recent experiments on animals have furnished results that permit the hope of future success.

Besides these labours the Commission succeeded also in acquiring information as to the conditions that favour the development of cholera in Calcutta—a question of much interest and capital importance.

Outside of India, in cities which have not been attacked by cholera, unless at long intervals, it is impossible to determine with security the salutary influence that certain hygienic measures, such as improvement in the quality of drinking-water, and drainage of the soil, etc., have over cholera; therefore the fact of cities having been preserved one or more times from the scourge, is found always to be subordinate to accidental causes. In the meantime, in cities such as Calcutta, which present yearly a considerable mortality, any hygienic measure that has an effective action against the malady, must lead to a manifest diminution of mortality.

Now, from 1870 onward, cholera has suddenly diminished to a very evident extent in Calcutta. Before that year the mean annual mortality from cholera in Calcutta, was 10.1 per 1000 inhabitants. Since 1870 it has come down to 3 per 1000. This fact deserves attention, and it ought to contribute to the effectual combatting of the scourge.

According to the almost unanimous opinion of physicians here, the diminution of cholera is to be attributed to the establishment of a good supply of drinking-water. The Commission felt it to be their duty to form their opinion in this relation, from actual inspection. For this purpose they visited the hydraulic works and the system of water supply of Calcutta. They made a series of analyses of the river water, before and after its filtration at Pultah, and they found that the water destined for the use of the population possesses excellent qualities.

Through the medical journals the French Com

mission charged with the study of cholera in Egypt, declare, in their report, that they have obtained results that differ from those which I have had the honour of making known to your Excellency, and of having found in the blood micro-organisms special to cholera. In view of this statement your Excellency may have been led to suppose that the German Commission has succeeded badly in its investigations; I therefore regard it as my duty to make known to your Excellency my opinion in this relation.

In the human blood we find, along with the red and white corpuscles, small rounded, pale elements, varying in number, denominated by us *Blutplättchen*. In various pyretic diseases, as petechial typhus and pneumonia, the number of these elements increases. In consequence of the resemblance which these elements have to micro-organisms, they have been confounded with bacteria.

These elements are met with in quantity in the blood of choleric and their cadavers, as I have verified. Moreover, it is not a new fact; other observers had before announced it. Dr. Cunningham, in his work, "*Microscopical and physiological researches into the nature of the agent producing cholera*," 1872, gave an exact representation of these elements in the blood of choleric.

Seeing that the most rigorous methods of investigation have never enabled us to discover in the blood of choleric other elements similar to bacteria, and that the description given by the French Commission of the elements mentioned, assimilates in every point to the *Blutplättchen* above mentioned, I am forced to admit that the French Commission has fallen into the same error as other observers who have taken these *Blutplättchen* for specific organisms. These elements cannot have any etiological relation to cholera, for, as has already been said, they are met with in the blood of persons in a healthy state, or those who have been attacked by diseases different from cholera.

THREE CASES OF NECROSIS OF THE LOWER THIRD OF THE FEMUR.

BY THOS. R. DUPUIS, M.D., ETC., KINGSTON, ONT.

Both caries and necrosis of bone are common enough diseases, and their pathology and general treatment I shall not attempt to discuss. Volumes

have been written upon them and every surgical work contains sufficient information for the guidance of the general practitioner. My object is simply to place before the readers of the LANCET a few thoughts on necrosis occurring in that peculiar, yet comparatively frequent site, the popliteal surface of the femur, and to record the success that has attended the cases in which I have operated, by thorough removal of the sequestra. Three cases are not many indeed, but following each other in close succession and yielding such satisfactory results as they have, render them worth a passing notice.

As is well known caries attacks the most vascular parts of bone, and bones distinguished by abundance of cancellous tissue such as the vertebrae, sternum, innominate bones, the carpus, tarsus and the articular extremities of long bones, notably the femur, tibia and humerus. Necrosis, on the other hand, is more strictly confined to long bones, and especially to those which lie superficial or close under the integument, and are thus more liable to injury from blows, changes of temperature, etc. Recently, however, I had under my care a case of necrosis of the posterior portion of the sacrum in a saddler, who had sat much on his bench. I removed several pieces of bone. Some years ago I had a case of extensive necrosis and exfoliation of the outer table of the frontal bone in a sewing girl who used frequently to strike her forehead against some part of her sewing machine when stooping over to thread the needle or regulate the thread. In reality, therefore, there is no obvious line of demarcation between the sites of caries and necrosis, the one or the other depending greatly upon the structure of the part attacked and the activity of the circulation in it. According to Mr. Timothy Holmes, chronic inflammation of bone is generally the result of one of three causes, namely syphilis, rheumatism, or injury, and he thinks this arrangement of causes indicates their order of frequency. Every practitioner of experience must be familiar with examples of diseased bone from various causes. Those practising in large cities will, as a rule, see more of the results of syphilis, while those practising in small towns and country places will be the better acquainted with diseases of bone from rheumatism and injury. I cannot, however, consider rheumatism a frequent cause of either caries or necrosis,

for although I have repeatedly witnessed changes in the articulations of bones from rheumatism, such as eburnation, exostosis, apophyseal enlargements, etc., I can recollect only two cases in which necrosis of bone followed acute rheumatism, one being a case under my own care in a girl about fourteen years of age, and the other case in a girl of about the same age upon whom I saw another surgeon operate for the removal of the sequestrum. The seat of the necrosis in both cases was the external surface of the upper part of the shaft of the right humerus. Bone affections from syphilis are too common, assuming almost every variety, and attacking almost every part of the osseous system. Those from injury may of course be found in any bone liable to external violence; yet they may be more or less limited to certain situations, because some parts are much more susceptible of morbid action than others, and thus an injury which in one situation would develop into inflammation and necrosis would in another pass off without serious consequences. The greater susceptibility to morbid action accounts for the frequent occurrence of necrosis in the popliteal portion of the femur, following injury to that bone; the chief causes of this being its vascularity and its great size where it expands into the two condyles. The patients of whom I write are not scrofulous, rheumatic or syphilitic as far as I could discover, and the necroses for which I operated were purely traumatic, although no one can deny the fact that their osseous systems must have been somewhat more liable to disease than is compatible with a perfectly healthy constitution.

The first case was a laboring man, aged 26 years, who had suffered for about fourteen years with fistulous openings about the popliteal space. They discharged large quantities of pus and occasionally small pieces of bone, healed and re-opened, and new ones opened when the old ones healed, and they were accompanied by all the symptoms of dead bone. The history of his case was that he had been hurt upon the leg above the knee by a blow from a stick, when a boy of 12 years old, while he was at work picking up chips and brush in a "new fallow," where men were "logging." After receiving the blow his leg swelled greatly, pained him very much, was poulticed and fomented for a long time, and finally "lanced," by which operation a large quantity of pus was liberated.

From that time the wound could never be healed, and he was regarded as being afflicted with a "fever sore."

Examination revealed a sequestrum of dead bone inclosed by new growths between which were numerous cloacæ through which the discharges found their way. He was greatly reduced in flesh and strength, unable to walk about without crutches, and in every way in a very unpromising condition. After due consideration of all the circumstances, and at his request, I decided to operate upon his leg. Preliminaries having been arranged an incision over four inches in length was made into the popliteal space in such a direction as to lie to the inner side of the external popliteal nerve and to the outer side of the vein and artery. On reaching the bone it was found necessary to use the chisel and mallet to cut away the new growths, and liberate the sequestrum. The largest piece removed was nearly four inches in length, jagged at the ends and presented a generally worm-eaten appearance. All small pieces were carefully taken away, and the cavity thoroughly washed out with carbolic water, 3 per cent., by means of a syringe. The operation was performed on the 15th of May, and he was well on the first of the following September. The man continues strong and well (now over three years) and earns his living by sawing wood and other laborious occupations.

The second case was that of a laboring man aged 33, who when between nine and ten years of age while attending school hurt his leg. He and the other boys used to go in swimming, and after coming out of the water to run and jump about violently for a length of time. One day he hurt his leg during this exercise, and it was attacked with severe pain, great swelling supervened, formation of pus, and its discharge by "lancing," followed, and for a year he was entirely laid aside. He gradually recovered partial health and strength so as to be able to work when he grew to be a man, but the sores resulting from the injury could never be got rid of. When he came under my care his leg showed evidence of several sinuses having healed, but two—one from each side of the limb which communicated—were open and discharging freely. It looked almost incredible that a sequestrum could be so long in dissolving, but it was true nevertheless, for examination revealed dead bone. An operation similar to the preceding one was

performed on the 3rd of March last, a piece of decaying bone two inches in length was removed, and by the end of April, the wound was entirely healed.

The third case was a healthy looking boy, aged 13 years, who had got his leg hurt by wrestling about a year previous. Usual history of such cases, pain, swelling, suppuration, and open sinuses. Examination revealed dead bone. As the sequestrum here lay upon the outer part of the posterior surface of the femur, I reached it by cutting in from the side, just in front of the tendon of the biceps. The bone was easily reached, the dead portion removed without difficulty. In six weeks the wound was healed, and the boy went home well.

What I claim for these three cases is, that they show the propriety of removing dead bone at the earliest possible opportunity, the ease and safety with which sequestra may be removed from the posterior part of the lower third of the femur, if proper care be exercised, and the frequency of necrosis, in this peculiar site. The first patient had suffered for nearly fourteen years, and was well in about 3½ months after the operation. The second had suffered for 23 years and was cured in about two months by operation. The third case had been going on for a year, but was terminated by a return to health in six weeks after operation. In all of them Esmarch's bandage was used during the operation and bleeding was almost *nil* after removal of the bandage. The drainage tube was inserted into the lower part of the wound and the rest of it brought together with sutures; carbolic oil and lint was applied to the wound and the leg enveloped in a roller bandage from the foot upwards. No bad symptoms followed any of the operations, all progressing favorably to the cure.

ON EXCISION OF THE TONSIL.*

BY G. STERLING RYERSON, M.D., L.R.C.S., E.

Lecturer on the Eye, Ear and Throat, in Trinity Medical College, Toronto.

The question, "When should a tonsil be excised?" is an exceedingly practical one which comes up for discussion almost every day in practice. The answer it would be well if possible to define precisely. The indications for excision I consider

to be the presence of symptoms either of impaired nutrition with marked obstruction to respiration, frequent relapsing, inflammation or suffering in contiguous parts.

Marked enlargement of the gland is almost sure to be accompanied by impairment of the general health, partly through the imperfect circulation of the blood, and partly also because of the broken rest at night. It is also probable that the stomach suffers from the constant swallowing of unhealthy mucus. Obstruction to respiration is a serious matter in the young, inasmuch as it causes the deformity of the chest, known as "pigeon breast." These symptoms demand the removal of the offending gland, because there is not time to wait for the slower action of internal and local remedies. The Eustachian tube and middle ear are very apt to suffer from inflammation by contiguity. The nasal mucous membrane also may, and frequently does present symptoms of severe inflammation and consequent obstruction of the nose. These symptoms also demand most urgently the removal of the tonsil.

Tonsils, the seat of chronic relapsing inflammation, should be removed. Also cases of true pathological hypertrophy of the tonsil are best treated in the same way, medicinal treatment being nugatory. The tonsils are frequently enlarged in strumous and delicate children; if there be no symptoms as before related, they are best left and treated by internal remedies, prominent among which are syr. of the iodide of iron and compound syrup of hypophosphites. Local astringents may also be used with benefit. In cases of follicular tonsillitis it is not often necessary to remove the gland. Local treatment with fused nitrate of silver on a probe applied to each follicle is generally successful. Mere enlargement of the gland without other symptoms, I do not consider to indicate its removal.

With regard to the mode of operation, the cases must be selected. For large, prominent tonsils, especially in children, the tonsillitome is, in my opinion, best suited. In moderately enlarged and very hard tonsils, in true hypertrophy and in the long, flat-shaped tonsil, the vulsellum forceps and blunt bistoury should be used. It is almost impossible, however, to use the bistoury in the case of young children, without an anæsthetic. I do not regard the danger of hemorrhage as a very

* Read before the Ontario Medical Association, June, 1884.

serious one. It is very rare, and it can be controlled by pressure on the artery, local tampon, or in extreme cases by ligature of the carotid. It is most dangerous in children who do not know enough to assist the operator.

THE LOCALIZATION OF PERINEPHRIC LESIONS BY MEANS OF CLINICO-ANATOMICAL STUDY.*

BY JOHN B. ROBERTS, M.D., PHILADELPHIA.

The author stated that his paper was suggestive rather than demonstrative or conclusive; and that he hoped the Fellows of the Association would investigate all cases of perinephric disease, which they met, with a view to definite localization.

The lesions liable to involve this region primarily or secondarily, are inflammation, abscess, cancer of the kidneys, cystic degeneration, renal calculi, hydronephrosis, etc. The early recognition of the exact seat of such lesions can only be attained by study of anatomical relations and clinical histories. The importance of such localizing knowledge will not be gainsaid in these days of nephrotomy, nephrectomy and kindred operations. As the study of cerebral localization has now advanced beyond the stage of speculative physiology, and has become of practical value to the physician and surgeon, so will the study that leads to localization of perinephric lesions become of future value. The symptoms and signs which must guide us in fixing the exact site are those due to extension of inflammation to adjacent structures, and those caused by increase of bulk and consequent pressure at the seat of disease. These may be termed the localizing symptoms as discriminated from the inherent symptoms of the lesion itself.

Although there are no dividing lines separating the perinephric area into tracts, it is convenient to speak of upper, middle, and lower anterior, and upper, middle, and lower posterior tracts.

The speaker then discussed the various symptoms likely to be produced by lesions in these different tracts; and from the clinical histories of cases reported by himself and others, and from anatomical study deduced the following conclusions:—

A table of symptoms of probable and possible value in localizing perinephritis and perinephric lesions. All anterior regions.—Pain, tenderness, swelling, cedema, pointing, etc., in front and side of abdomen. All posterior regions.—Pain, tenderness, swelling, cedema, pointing, etc., in loin. Upper tracts.—Pleuritic friction, pleural effusion, empyema, expectoration of pus, dyspnoea, supra-renal involvement, solar plexus involvement. If on right side, bilateral cedema of legs, jaundice, fatty stools, persistent vomiting, rapid emaciation, ascites. Middle tracts.—Albuminuria and casts; suprapubic, scrotal or vulvar pain or anæsthesia, suppression of urine, uræmia, pus in the urine, cedema of scrotum or varicocele, especially on left side. Lower tracts.—Flexion of hip, pain or anæsthesia of front, inside or outside of thigh, retraction of testicle, pain at knee, scrotal or vulvar pain or anæsthesia, without accompanying albuminuria, unilateral cedema of legs, abscess or sinus near Poupart's ligament, constipation (if left side), involvement of chyle receptacle (if right side).

Correspondence.

THE PUBLIC HEALTH BUREAU.

To the Editor of the CANADA LANCET.

SIR,—In the May number of the LANCET, in an article on "Public Health," it is stated that, the meeting of the profession which was held here in March to consider the Dominion Health Bureau question, ignored (though not intentionally) "the body that had hitherto conducted such work," referring, I suppose, to a special committee, which had been appointed for two or three years, previous to last year's meeting of the Canada Medical Association at Kingston, but which at the last meeting was not re-appointed; hence there was no such committee as that to which you allude to "conduct the work." Besides, the medical men in the House being legislators and representatives, considered that with them might most properly originate any such movement as the one upon which action was taken. It was the intention to fully consult the *public health* committee of the Association in reference to the proceedings before any legislation took place. Furthermore, at that meeting there were about twenty-five medical men, while at the latter meeting to which you refer, when the resolution

* Read before the American Surgical Association at Washington, D. C., May 2nd, 1884.

was passed that 'further consideration be deferred' &c., there were, I think, not more than about six. Later again another large meeting was held, at which, besides many members of the House (medical) were some twelve or fifteen medical men from Quebec Province, which concurred in the main with the action of the first meeting, as did the deputation concerning sanitary matters from the province of Quebec. It was the strong desire of all that there should be 'united' action. By giving the above publication you will oblige,

Yours truly,

EDWARD PLAYTER.

Ottawa, May 26th, '84.

Reports of Societies.

ONTARIO MEDICAL COUNCIL.

The annual meeting of the Medical Council of the College of Physicians and Surgeons of Ontario was held in Toronto on the 10th ult., Dr. G. Logan, of Ottawa, President, in the chair.

Dr. V. H. Moore, representing Queen's College, was enrolled as a member. After routine the President delivered his valedictory address. He alluded to the satisfactory manner in which the officers and board of examiners had discharged their duties. In regard to the matriculation examination, it was found that the Education Department, while requiring of all students in Latin only 20 per cent. for pass, demanded from those who had previously passed the intermediate and came up for the Latin only, 40 per cent. for pass. Regarding this as unfair, he directed the registrar to pass all students who made 20 per cent. and upwards in Latin. He granted no permits to practise during the year nor stayed proceedings in any case. He was urged to undertake the expense of the defence of Drs. McCammon and Bray in the recent libel suit, but in consulting the solicitor, he was informed that such action would be illegal. He thought the Council should at once endeavor to obtain power to punish those who violate well understood rules of the profession. Dr. Day was then elected President for the ensuing year and Dr. Spragge Vice-President.

The following Standing Committees were next appointed:—Registration Committee—Drs. Rosebrugh (*Chairman*), Vernon, Bergin, Fenwick and J. W. Wright. Rules and Regulations—Drs. Mc-

Donald (*Chairman*), Grant, Rosebrugh, Campbell and J. W. Wright. Finance—Drs. Edwards (*Chairman*), Allison, McCargow, Henderson and Douglas. Education—Drs. Lavell (*Chairman*), Geikie, Moore, H. H. Wright, Edwards, Burritt, McDonald, Husband, Logan, Williams, Burns, Cranston, Bray, Fenwick and Buchan. Printing—Drs. Vernon (*Chairman*), Moore, Campbell and Burritt.

Petitions and communications were then read and referred to the proper committees. The report of the Curriculum Committee was also read and referred to a committee. The report of the Board of Examiners was referred to the Education Committee.

The special committee appointed last year to make arrangements for the sale of the College Building, reported that they had an offer of \$15,000, but they understood that the value of property in the neighborhood was rapidly advancing, and advised delay. They had an offer of a site near the Toronto University on very favorable terms.

June 11th, 1884.

After reading the minutes, several notices of motion were given and petitions read, among others, one from Mrs. Dr. Corlis, of St. Thomas, asking to be registered as a matriculated student, which was referred to the Registration Committee.

Dr. Fenwick then moved, that after this date examinations for medical students be held in the city of London, in addition to the examinations in Toronto and Kingston. After considerable discussion, the motion was ruled out of order, as the Act expressly states Toronto or Kingston.

Dr. Burns introduced a by-law, which was passed, to regulate the election of representatives to the Council, which will take place on the last Tuesday in May, 1885, and also for the appointment of returning officers. The by-law requires that every candidate who seeks election must have the signatures of at least ten registered practitioners resident in the Division, attached to the nomination paper. The following are the names of the returning officers:—Drs. G. E. Richardson, Chatham; J. S. Edwards, London; H. P. Yeomans, Mount Forest; H. McKay, Woodstock; W. T. Harris, Brantford; T. W. Reynolds, Hamilton; J. E. White, Toronto; R. J. Gunn, Whitby; R. W. Bell, Peterboro'; W. Hope, Belleville; A. J. Horsey, Ottawa; J. W. Pickup, Brockville.

The report of the Treasurer was then read. The

receipts during the year were \$9,549.88, including a balance from last year of \$2,163.98; the examination fees from pupils and the registration fees from physicians, amounted to \$6,370.28. Less than \$200 was received from fines inflicted upon illegal practitioners. The expenditures amounted to \$5,658.14, which included a payment of \$1,081.86 to members of the Council, about \$1,500 for salaries, and \$1,331.60 to examiners, leaving a balance on hand of \$3,891.74. No payments have been made towards liquidating the debt on the building.

The following changes were made in the Curriculum, but they do not come into force until one year from date :—

Graduates in Arts will hereafter be required to take a four years' course and be examined in all the subjects comprised in the professional examination.

Permission is given students to spend the six months necessary in compounding medicines, in a drug store or in the office of a physician. A new clause was added, which provides that each candidate for the final examination must present a certificate of ability to make and mount microscopic specimens; attendance at six post mortems, and a certificate of ability to draw up a report on a post mortem examination; also a certificate of having reported satisfactorily on six cases of clinical medicine and six of clinical surgery. A change was made in the primary examination, so as to make them "written" and "oral," instead of "oral" only as heretofore. "Therapeutics" has been transferred from the list of subjects in the primary to the final examination, and "Pharmacy" is inserted instead of Botany, which is struck out entirely.

June 12th.

The Council met at 10 a.m. After routine, Dr. H. H. Wright called attention to the fact, that owing to a defect in the Anatomy Act, there was a scarcity of "subjects" for dissection, and asked the members to use their influence with the members of the Legislature to secure necessary amendments.

The following motion by Dr. Bray was then carried :—"That it is desirable in the interest of medical education, that increased facilities for the study of human anatomy should be provided, and that a committee consisting of the vice-president and members of the Council residing in Toronto, be instructed to wait on the Ontario Government for the purpose of inducing the Legislature to pass the Anatomy Act,

and that a copy of this resolution be sent to each member of said Legislature as embodying the views of the medical profession of Ontario."

Dr. Burns moved that Drs. Cranston, Henderson, McDonald and Edwards be a committee to act in conjunction with the Ontario Medical Association to obtain a grant for a pathological museum from the Local Legislature.—*Carried.*

Dr. Williams moved,—“That this Council when seeking further legislative powers from Parliament, should endeavor to obtain the right to appoint a medical practitioner in each electoral division, to tax all medical bills that may be under dispute and referred for his decision, and that such decision shall have the same legal effect as the taxation of bills of costs by the taxing master of the legal profession.—*Carried.*

Dr. Buchan moved that Drs. Geikie and Douglas be appointed to represent the Council at the approaching meeting of the British Medical Association and at the International Medical Congress at Copenhagen.—*Carried.*

The report of the Building Committee, which was adopted, recommended that a site be selected for the erection of the College near the University.

The following officers were elected for the ensuing year :—Dr. Pyne, Registrar; Dr. Aikins, Treasurer; D'Alton McCarthy, Solicitor.

June 13th.

The first business was the consideration of the report of the Finance Committee. A by-law was passed granting an increase of salary to the Registrar, from \$1,000 to \$1,200.

Dr. Lavell presented the report of the Education Committee, which was adopted. It recommended that the Council accept a county board teacher's certificate of qualification, when endorsed by the Educational Department, as being equivalent to the Intermediate High School certificates on the third non-professional of 1884, as now required by this Council; that no equivalents be accepted in lieu of lectures or hospital practice; that the examiners of last year be re-appointed, with the exception of Dr. Nicol, for whose name that of Dr. Anderson, of Hamilton, be substituted.

The Committee on Legislation recommend that a bill be presented to the Legislature providing that the annual fee paid to the Registrar be raised to \$5, which may be commuted by a life payment of \$20; that a clause be inserted in the Act providing that no school or college not having a medical faculty shall hereafter be admitted to representation in the Council; that a taxing master be appointed for each electoral division; that the Council shall have power to establish a code of ethics, and in the event of any violation of the code to punish the offender by suspension or erasure of his name from the register of the College, such action to be preceded by examination by the Council, the same to have power to examine wit-

nesses on oath. This latter clause has special reference to the following paragraph from a petition presented to the Council:—"We also beg this Council to urge upon the Ontario Government the necessity to introduce a clause giving to this Council the power to cancel the licenses of those who engage with parties outside of Canada, acting as their agents, thus putting the law at defiance to the great detriment of those practising in this Province."

ONTARIO MEDICAL ASSOCIATION.

The fourth annual meeting of this Association was held in Hamilton on the 4th and 5th ult, Dr. D. Clarke, President, in the chair. There were a large number of members present, and the proceedings were commenced by the reading of the minutes of last session. A communication was then read from the Women's Christian Temperance Union, asking among other things, what ought to be the attitude of the medical profession towards the sale of intoxicants? The matter was referred to a committee.

The reading of papers was then taken up, the first one being by Dr. Workman, of Toronto, on "Aphasia." He was received with great applause by the members, and his paper was listened to with much interest. The paper, which was a very able and interesting one, will appear in the next issue of the LANCET. An interesting discussion followed, in which many of the members took part, and a cordial vote of thanks was tendered the author. It was also decided to have the paper printed.

On taking the chair in the afternoon, the president delivered his opening address. After expressing his thanks to the association for the honor conferred upon him, and his hope that he might be able to discharge the duties of the office in the same admirable manner as the Nestors of the profession who had preceded him in the presidential chair, he proceeded to say he would devote his paper to a mild criticism of matters appertaining to the profession, but hoped that any wounds inflicted would be treated as those of a friend. The first matter referred to was the increase in educational facilities during the last few years, which he considered a matter of congratulation, and that there was no excuse for students with their present facilities and privileges, the results of which are to be seen in the improved culture of the younger members of the profession. In connection with this improved culture, he thought that great credit

was due the colleges and central licensing body for the institution of a higher curriculum. Reference was then made to the low state of the professional standard twenty-five years ago, this low standard being due to the number of "irresponsible colleges, boards and isms, while licensing bodies held out strong inducements in the shape of a low standard to students "anxious to become full fledged in the shortest possible time." As a result the body which offered the strongest inducement got the most money and the practice degenerated into a mere matter of business competition. The many excellent practitioners then educated and now amongst the most gifted members of the profession had, he thought, become so from natural aptitude, not from any advantages of the system then in vogue. Then there was a demand for practitioners; now there was an over supply, and it was apparently a question of the survival of the fittest, but supply would regulate the demand. In the United States there is now a great effort being made to rectify this error and all colleges and societies are calling for reform, the evil sought to be remedied being shown by a quotation from a report of Dr. Wright to the New York Medico-Legal Society. Now the great evil is a tendency to specialties, the number being absurd; for though some were adapted to men of special aptitude who, like poets, are born with enthusiasm for knowledge in certain fields for which they are congenitally suited, these were individuals and not classes. Outside of cities the practitioner must be equipped fairly and have a many-sided knowledge. In speaking of these general practitioners, an exception must be made of the non-reading members, the old fossils who trusted to their general knowledge, which would be the better for an extended reading. He administered a fitting rebuke to those members of the profession who adopt the method of the quack in publishing their cases in the local paper. He then referred to the various advertisements in the different papers, both religious and secular, many of which by their covert allusions, did great mischief to the morals of the community, especially to those of weak minds; allusion was also made at some length to many of the advertisers who were really worse than criminals. In conclusion reference was made to the attitude which should be adopted by the profession in regard to prognosis and the evil of magnifying the disease of patients, in order to obtain credit for remarkable cures. He counselled a cheerful countenance, as much attention was paid to the countenance of physicians by the public; lastly, he gave a quotation from Punch, on the hardships of physicians, finishing with a statement of the proper position in reference to other medical men, and the public.

Dr. Howe, of Buffalo, delegate from the New York Medical Society, was then introduced; Drs.

Workman, Covernton and Macdonald were also invited to seats on the platform. Dr. Tye then read his paper on the "Management of the third stage of labor." Considerable discussion followed, Drs. Macdonald, Hamilton; Geikie, Toronto; Bray, Chatham; Bryce, Toronto; Stark, Hamilton; Brouse, Brockville; Macdonald, Toronto; Richardson, Toronto; Griffin, Brantford; Mullin and Rosebrugh, Hamilton, taking part. Next came Dr. Powell's paper on "Later antiseptics in private practice," illustrated by specimens of the newest materials, such as peat, wood-wool, iodoform gauze, corrosive sublimate gauze, decalcified bone tubes, etc. The discussion which followed was taken part in by Drs. Burt, Paris; and Turver, Parkdale. Dr. Griffin, of Brantford, described a case of tumor in the abdomen, the specimen being shown. Drs. Sheard and Graham, of Toronto, made remarks on the paper. Dr. Brouse, of Brockville, followed with a paper on "Ovariotomy and Strangulated Hernia," in which Drs. Groves, Fergus; Campbell, Seaforth; and Turver, Parkdale, spoke.

In the evening session, papers were read by Drs. Burnham, Thorburn and Adam Wright, Toronto, and Turver, Parkdale. During the evening the Mayor was introduced and addressed the meeting, welcoming the members.

SECOND DAY.

The chair was taken at 10 a.m. After routine Dr. Graham, of Toronto, read a paper on "Idiopathic Anæmia," giving the history of seven cases. The origin of this obscure disease was he thought in the nervous system. Fowler's solution was he thought the only remedy of any value. In the discussion which ensued, Dr. Arnott, of London, said he had experienced great satisfaction from the use of eucalyptus. Dr. Sheard, Toronto, thought an error was made by us in referring all obscure diseases to the nervous system; he thought that the fluids of the blood might possibly be in such an abnormal condition as to produce the changes found in the blood corpuscles. Dr. Cameron, of Cayuga, thought it might be of a similar nature to scorbutus caused by lack of sufficient vegetable food. The president and others also discussed the paper, after which Dr. Groves, of Fergus, read a paper on "Operations on the chest for removal of pus or other fluid from the cavity of the pleura." Dr. Powell said he used the syphon principle in his operations, and showed by means of the instrument which he used his method of treatment. The discussion was also participated in by Drs. Aylesworth, of Collingwood, Richardson, Temple and Bryce, of Toronto.

Dr. Hutchinson, Brussels, then read a paper on "Hodgins' Disease," and illustrated it by a girl aged 10, suffering from the disease, who was present.

Dr. Worthington, of Clinton, read a paper on "Cerebro-spinal Meningitis," which gave an account of an epidemic seen in his neighborhood during 1871-72. Drs. Harrison, of Selkirk, McCargow, of Hamilton, White, of Toronto, Campbell, of Seaforth, and Turver, of Parkdale, gave their experience during this and other epidemics.

Dr. Alexander exhibited a patient with an obscure affection of the knee joint, which had started apparently from an injury two years ago, followed by another about a year ago. The joint itself was very weak, bending inwards when the man walked, while there was great enlargement of the lower part of the thigh. After some remarks on treatment from Drs. Sheard, Toronto, and Groves, Fergus, Dr. Osborne, St. George, showed a patient who had a peculiar growth near the inner angle of the left eye that had been gradually increasing in size for the last seven years.

A resolution was then moved and seconded by Drs. Powell, of Edgar, and Fulton, of Toronto, and carried, with reference to the work of the several temporary committees which was to ensure better attention to their reports by appointing a special subject for the consideration of the committees a year in advance, the chairman to open the discussion on the same.

Dr. Rosebrugh, of Toronto, then read a paper on "Boracic Acid and Boro-glyceride in the treatment of purulent inflammation of the middle ear."

The next paper was by Dr. Riordon, Toronto, giving an account of a case of double uterus and vagina.

Dr. Harrison, Selkirk, then read a very witty and able paper on vaccination, defending the practice against some of the attacks made on it. Drs. McCargow, Hamilton, and Campbell, Seaforth, made remarks on the subject, while Dr. Bryce spoke on the subject of the supply of vaccine and the difficulties to be met with.

Dr. Brown, of Galt, read a paper entitled, "Glimpses of Transatlantic Surgery," giving an account of operations and methods adopted in the principal hospitals abroad. The last paper was read by Dr. W. H. B. Aikins, of Toronto, on the local treatment of spermatorrhœa. The report of the committee on "Medical Ethics" was left for consideration at next year's meeting. The report of the committee on the communication from the Women's Temperance Union, was also left over. A special committee was appointed to report on the subject of Bacteria at the next meeting. The Committee on Nominations reported as follows, and the report was adopted:

President, Dr. Worthington, Clinton; 1st Vice-President, Dr. Tye, Chatham; 2nd Vice-President, Dr. Richardson, Toronto; 3rd Vice-President, Dr. Brouse, Brockville; 4th Vice-President, Dr. Powell, Edgar; General Secretary, Dr. J. E. White, Toronto; Treasurer, Dr. J. E. Graham, Toronto;

Corresponding Secretaries, Dr. Irwin, Kingston; Dr. Harris, Brantford; Dr. Waters, Cobourg; Dr. Hutchinson, Brussels.

It was decided to hold the next meeting in London. After the usual votes of thanks the meeting adjourned.

ONTARIO BOARD OF HEALTH.

The third annual meeting of the Ontario Board of Health was held in Toronto on the 30th of May. The newly appointed chairman, Dr. C. W. Covernton, delivered his inaugural address, in which he dwelt upon "sanitary matters in connection with public health. The principal topic was the removal of sewage in large cities, and Toronto in particular, alluding to the different methods of disposal, precipitation, trunk sewer, etc. The reading of communications followed.

The report of the Committee on Epidemics, etc., contained many illustrations of the necessity for greater public attention to vaccination, greater care on the part of physicians in detecting the disease in its early stages, and more speedy and energetic action by local Boards of Health.

The report on the diphtheria epidemic which occurred some months ago at Smith's Falls, contained striking illustrations of how the disease spread by lack of isolating precautions on the part of householders, and carelessness of physicians and local Boards of Health in carrying out disinfecting measures.

The Board referred the matter of the ventilation of schools to Dr. Cassidy. The Publication Committee was authorized to send to each municipality a specimen blank book for the reports required to be given by local Boards of Health. The secretary was requested to prepare a circular regarding neglect to notify the Board of the formation of local Boards. A committee was appointed to prepare a specification for a system of dry removal of excreta adapted to the circumstances of small towns.

Prof. Galbraith, Drs. Rae, and Bryce, were appointed delegates to attend the meeting of the Ontario Medical Association at Hamilton on June 4th.

A discussion took place upon the introduction of small-pox by immigrants, and it was decided to communicate with Dr. Tache, Deputy Minister of Agriculture for the Dominion, and with the rail-

way managers, concerning the necessity for more extended and systematic action between the Dominion, the Provinces, and the railway authorities for the inspection of immigrants from their arrival at the port of entry till their distribution in the Dominion or passage into the United States.

The following committees for the ensuing year were appointed:—Epidemic and Contagious Diseases—Dr. Covernton, Dr. Bryce. Sewerage and Water Supply—Dr. Oldright and Prof. Galbraith. Foods, Drinks, Adulterations—Dr. Bryce. Buildings and Ventilation—Dr. Cassidy. Poisons—Dr. Rae. School Hygiene—Dr. Yeomans. Legislation—Dr. Bryce. Publication—Drs. Oldright, Covernton, and Cassidy.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.

At the regular meeting of this society a paper was read by Dr. Small upon '*Simple continued fever.*' He referred to the fact that the Royal College of Physicians adopted the name in their nomenclature to cover all anomalous cases of continued fever that could not be classed with Typhoid or the other well recognized forms. The ambiguous definitions, descriptions, and points for diagnosis as found in the various books, were pointed out. A fever coming within the descriptions was very prevalent in Ottawa, but observations showed that a specific or miasmatic influence was its cause, in this point differing from the various authorities. The question whether it should be regarded as a distinct fever or a type of Typhoid was discussed. The writer was inclined to accept the theory that all fevers were due to a germ, which, under the influence of certain conditions produced in one case a simple continued fever, and in another a severe type of Typhoid. The conclusions of the paper considered the application of this theory to all other fevers. In opening the discussion the President, Dr. Powell, said he frequently met with these mild continued fevers, and although not contagious he could understand that they might be due to the same poison as Typhoid in a mild and altered state. Dr. Playter thought there was much in the view, and referred to the very different effects that could be produced on the system according to the cultivation of the bacilli. Dr. Prevost was always inclined to consider mild febrile attacks as a gastric or bilious fever. He also gave the history and exhibited

a patient with a chronic painless disease of the elbow joint.

The meeting then adjourned. A paper will be presented by Dr. Grant at the next meeting.

BRANT COUNTY MEDICAL ASSOCIATION.

The above Society convened in Brantford on Tuesday 27th May. There was a fair representation of members present, Dr. Harris, President, in the chair. The minutes of the last regular meeting were read and adopted. Dr. McCargow, of Hamilton, gave a very interesting paper on "Injuries, embracing wounds of the brachial, radial and posterior tibial arteries."

Dr. Tegart gave notes of three very interesting cases from his practice, namely, rupture of the uterus, strangulated hernia and metrorrhagia.

Dr. Griffin shewed a case of obscure abdominal disease resembling carcinoma.

Dr. Harris related a case of complete spontaneous inversion of the uterus, where he had successfully reduced the inversion, and complete recovery took place.

These papers were each fully discussed, Drs. Sinclair, Griffin, Tegart and others taking part.

After some routine business the Society adjourned to meet in Brantford on the first Tuesday in September next.

Selected Articles.

SAYRE'S EXTENSION SPLINT FOR DISEASE OF THE ANKLE JOINT.

Synovitis of this joint may occur through cold and exposure, but more frequently it is the result of a wrench or strain being followed by an acute effusion into the joint. You may also have an osteitis from the effects of a blow or concussion, which will bring about an effusion of blood into the cancellous tissue of the bone, which may be the cause of serious disease; in the course of time necrosis and caries following. Some authors term this, chronic disease of the joint, progressive disease of the joint. The reason why this disease is so slow in its progress, apparently assuming a chronic form, is simply because the injury which caused it was at the time very slight. A moderate amount of pressure being brought against the side of the joint may result in the extravasation of a single drop of blood into the cancellous bone-tissue; now this injury is so slight that the man

may continue at his work, but this slight injury, in perhaps from six to twelve months, has then produced such marked injury as to demand attention. In our examination, we then find increase of temperature, in the part, perhaps accompanied with a semi-fluctuating feeling and intense pain upon pressure in certain positions.

The diagnosis of osteitis is not always easy; there is usually pain, and if you apply the surface thermometer, you can detect an increase of temperature; on examining the joint, by using compression and extension, you will be able to detect the disease in either ligaments or cartilage. If you stretch the ligaments, it will cause pain if the disease be in the ligaments; if the disease be in the bone, the pressure upon the parts will produce intense pain. I do not believe that the disease commences in the cartilage itself, but being devoid of sensibility, it undergoes change and becomes necrotic after the bone has become diseased; the cartilage becoming absorbed, leaves the cancellous bone-tissue exposed, then the pain becomes excruciating. When the cartilage becomes ulcerated, there is a thickened condition of the synovial membrane ensuing, and its secretion becomes gelatinous and of a reddish color. If the disease be not arrested, caries of the bone takes place, and as soon as the slightest portion of the bone becomes dead it becomes a foreign body, and is the source of constant irritation until it is removed; the slow process of nature may, in time, burrow through the tissues, and thus the bone be discharged. The greatest difficulties that I have seen occurring in the ankle-joint, arise from very slight injuries.

A case that came under my treatment was that of a farmer who simply twisted his foot while plowing, and at the end of two or three years he had a diseased joint, which it was thought would require amputation. He was sent to me as a specimen of chronic disease of the joint, which is claimed to be the result of a strumous affection; but this is not so in the great majority of cases, and even in those persons of a strumous diathesis it will require some injury at a special point in order to form a primary lesion. In this case a large amount of bone was removed, and following this was an extensive hemorrhage; the wound was at once filled with oakum saturated with persulphate of iron; the man finally recovered with a good, useful foot, having a perfectly movable joint.

I saw a young lady two days ago who had had her ankle locked up for two years in a plaster-of-Paris dressing, without affording her any relief; but on the contrary, the disease was still progressing. There had been no extension made at the time the dressing was applied; the diseased surfaces had been locked up immovably, but they were still pressing upon each other, and hence absorption of the structures was still going on. She came to me, and I at once applied the extension

splint (Fig. 1), which gave her immediate relief. I removed the splint the next day, and at once the pain was as severe as before, showing that the articular surfaces being brought together caused this intense pain.

The extension splint which I use for the ankle-joint you will notice consists of an iron foot-plate with an anterior and posterior rod, each composed of two pieces, sliding into each other by means of a ratchet and key. These rods extending upward to just below the knee are attached to a collar, which passes around the leg. The posterior rod, just at the heel, has a joint at that point, while the anterior one is attached to the central portion of an arch passing over the foot. Just anterior to the arch the foot-plate is divided and hinged in order to allow of flexion of the toes—the foot-plate at the heel being slightly narrower than the heel itself in order that the foot may not slide from side to side. This point must be specially attended to when ordering the instrument.

In applying this instrument, I first pass inch-wide strips of the mole-skin adhesive plaster parallel with the leg from just above the ankle to the knee, placing them almost close together all around the leg, and securing them firmly by a roller-bandage. Then placing a piece of old linen under the foot upon the foot-plate of the instrument, to absorb moisture, I secure the foot in position with adhesive plaster to the instrument, as I here show you. (Fig. 2.) I now pass a roller bandage around the foot, over the plasters, and secure them firmly, leaving, as you observe, the ankle-joint exposed. Then securing the collar of the instrument just below the knee, I reverse the ends of the adhesive plaster over the collar, and then pass another strip of plaster around the collar over the other strips to hold them in place, supplementing the same with a roller bandage, which I pass down the leg also. You will now notice that the instrument is firmly secured, and I am prepared to make my extension, which I do by first keying out one rod and then the other, until I have reached the correct point, which affords most relief. This being done, I am now at liberty to make my compression around the joint as may be indicated, covering in the whole with a roller bandage. As the dressing is now complete, the parts are entirely covered in. But always make your extension at that stage of the dressing, as I just now showed you; do not make your extension after your dressing is complete and the parts are all covered, or strangulation may occur and necessitate the instant removal of your dressing.

If the ankle-joint be injured by a sudden shock, as from jumping out of a waggon, or from any height, put the foot at once into hot water, and keep it there for several hours, gradually increasing the heat of the water to as hot as it can be borne. On removing the foot from the water, ap-

ply a snug bandage, and keep the parts at rest for a few days. In the majority of cases you will find that this treatment is all that is required when applied early.

There are also a great many mild cases in which by massage for a number of hours you can restore the circulation and cause an absorption of the extravasation; this, however, is an experimental treatment which will not answer in all cases. You may sometimes secure absorption of the fluid in a few days by this method; it is at all events worthy of a trial. There is no law by which you can be governed as to the treatment by this means; you are safer, therefore, to rely upon giving the joint complete rest for a little while, until the inflammatory action has subsided. In some cases it may be necessary to apply leeches or cups to lessen the amount of blood in the part; but I prefer to use the cups and prick the parts with a sharp tenotomy; by this means you avoid the bad leech-bites. Persons who have a bad diathesis do not bear leech-bites well, as it may be followed by an erysipelatous inflammation. Many of these cases of ankle-joint disease are reduced to a bad condi-

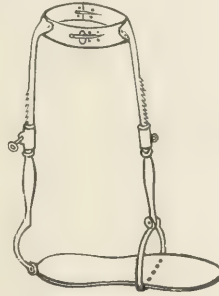


Fig. 1.

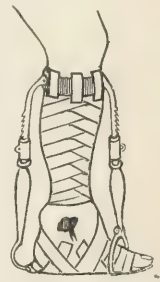


Fig. 2.

tion by the long-continued use of poultices. These solicit more blood to the part, and the foot becomes one boggy, doughy mass. Apply firm compression around the joint, and you will be surprised at the result. When the connective tissue becomes loaded with this exudation, the more it is poulticed the worse it will become. If the disease has gone on to suppuration, open the joint at once, and let out the pus, avoiding injury to all vessels and tendons; always cut parallel to the vessels and tendons. If you find the bone to be dead, take it out, as it is then a foreign body, and until it is removed there is no prospect of recovery. Keep the limb in the horizontal posture as long as the ankle throbs when brought to the ground. Do not let them assume the erect posture too early. You can never have an inflammation of the joint without a reflex action of the muscles following sooner or later, if the disease cannot be arrested. This, of course, gives rise to deformity, the stronger muscles prevailing; and hence the more common deformity is talipes equinus, with sometimes more or less valgus or varus.

To prevent that, you should always make extension. It is absolutely necessary to secure extension as well as rest for the part, the extension being applied with sufficient force to prevent compression of the articular surfaces—the contraction of the muscles then becomes *nil*. Very often there is an enormous amount of effusion around the joint, which can only be relieved by firm compression. In this case, use a large wet sponge, squeezing out all the water, then bind it firmly around the joint, after which dip the joint in water or pour water over it, and the sponge absorbing the moisture will secure greater compression. Many persons used to amputate these joints. I, however, think cases of diseased joints but seldom require amputation. Here (showing cast) is a case in which I was called upon to assist at an amputation of the ankle-joint. I came to the conclusion, after examining it, that an effort should be made to save the foot, as it appeared to be tolerably healthy. My suggestion was adopted. Extension was then made, and the foot secured in the manner described, with the most satisfactory results.

Case 3. This little child was brought to me three months ago, suffering from disease of the ankle-joint. At that time it was characterized by that peculiar boggy feeling which I have before described in these joint diseases. In this case the extension splint has been used, and in addition the sponge has also been applied around the joint to secure additional compression. The splint has now been worn for about two months. The mother states that the child has had no pain at all, and when the instrument is properly adjusted, she can play around the house with the other children. Now you observe here that by pressure upon the child's foot I cause no pain. To-day we will omit the use of the sponge, and now, having extended the joint, I make firm compression around it by means of the adhesive plaster and the roller bandage. You thus have the joint entirely at your control when dressed in this manner.

In those cases where an abscess appears and you find excessive inflammation, you can freely open the joint and let out the pus. In diagnosing for pus, hold one finger absolutely still and gently pass the other over the inflamed surface, in a line parallel with the long axis of the muscles; do not go from side to side of your finger which is stationary, or you will be deceived by the lateral movement you cause the muscular tissue to make; but go above and below with the long axis of the muscular fibre. By this means of slight compression you will cause the pus to pass under your other finger, and thus distinctly feel the fluctuation; this is a simple, practical point. In these cases the abscesses must be thoroughly evacuated either by aspiration or free incision; if the latter, it should be freely washed out antiseptically, and filled with Peruvian balsam, and dressed with

oakum; then allow your patient to get out as soon as possible. Now, if you thoroughly master the principles of this treatment, you can perform these operations equally as well as myself, and thus save the joint from amputation.

Case 4. In this boy's case the extension splint has been removed from the ankle, and in its place has been substituted a piece of sole leather which has been thoroughly wetted, and then moulded to the foot and ankle while it was extended; it was then bound securely to the joint with a roller bandage, and allowed to remain there until it had become thoroughly hardened, when it, of course, assumed the exact moulding of the parts; you then cover this leather splint on both sides with moleskin adhesive plaster, the adhesive side out, and apply it once more to the limb, at the same time making traction upon the foot and securing the splint to the foot with a roller bandage; this being accomplished, extension is now made, and your bandage continued above the ankle up the leg; the splint is thus firmly secured, and extension of the joint maintained sufficient to prevent attrition of its surfaces.

Often, in many of these cases where you are unable to secure the leather or extension splint, you can fold a piece of paper up very tightly, then cover it with a piece of adhesive plaster from end to end, on both sides, with the adhesive side out. Then bend it to fit the anterior portion of the foot, allowing it to pass up the leg. Now fold up another piece of paper, and cover in like manner, and apply to the sole of the foot and pass up over the heel. Having placed these in position, take a roller bandage and secure them firmly to the foot as far as the ankle. My assistant then making traction upon the foot, I continue my roller bandage above the ankle-joint and up the leg over the paper splint, the adhesive plaster holding it in position, and by this means my extension is maintained. In this case before you I shall again apply my extension splint, in order to make the adjustment more perfect. I merely show you the method of adjusting this leather or paper in such cases where you have not the opportunity of securing the iron splint.—*Med. and Surg. Reporter.*

CARCINOMA OF THE OMENTUM AND LIVER.—BARTHOLOW.

The case now on the table is a very interesting and instructive one. This man is 66 years of age and is a farmer. He has followed a laborious occupation all his life. He states that he was perfectly well until last October (five months ago), when he began to notice that stooping caused pain. One month later he discovered a tumor in the abdomen. There is now considerable pain caused by movement or bending of the body.

Looking at the abdomen, you observe that the

anterior surface is pressed up by a mass which is most prominent in the neighborhood of the right hypochondrium. Depressing the walls of the abdomen, I am able to get my fingers beneath the edge of this mass, and with a little effort I can lift it up to a certain extent. On the right side the thickness is somewhat greater. I have drawn a line around the edge of the tumor as it is determined by percussion. As you see, it is oval-shaped, with the point downward, and has to a certain extent the shape of the omentum, which hangs down in front of the intestines. The thinnest part is about one inch in thickness, and is in front.

The questions which we first encounter are, what is the relation of this mass to the organs within the abdomen, and is it connected with the liver, for you see the greatest thickness and prominence is in the neighborhood of the liver? With a little care I can insinuate my fingers beneath the ribs and between them and the tumor, and by careful percussion I am unable to find any marked difference in the percussion note over the liver and over the tumor. This mass, if separated from the liver, extends under the shelving border of that organ and comes in contact with it. In front, light percussion over the tumor gives a dull note, while stronger percussion develops distinct tympanites. Light percussion throws into vibration the hard mass which lies in the anterior part of the abdomen, while deep percussion brings out the tympanic note of the stomach and intestines which lie beneath the mass. This indicates that the mass is in front of these hollow organs. What organ is there in front of the stomach which, being diseased in this way, would lie in this position? Of course, that organ is the omentum.

I shall next examine the condition of the aorta which, running beneath the tumor, might come into relation with it. Listening with the stethoscope, I hear the ordinary sounds. There is nothing to indicate that the aorta is pressed upon. By simply pressing firmly enough the stethoscope on the aorta, the sounds characteristic of aneurism may be developed. It sometimes happens a diagnosis of aneurism of the aorta is made in this way. If this tumor pressed upon the aorta we should expect to have pulsation, thrill and bruit. There is nothing to indicate pressure on the aorta; on the contrary, the sounds heard indicate that the aorta is not impinged upon. We have in this fact an additional reason for believing that the mass lies in front of and is distinct from the aorta and adjacent organs.

The appetite is poor, and there is a sense of fullness after eating even a small quantity of food, although there are no eructations. This sense of fullness is evidently simply mechanical, the mass in front preventing any distention of the stomach. There is no indication that the stomach is involved.

From a consideration of these various points I

come to the conclusion that this mass is connected with the omentum, and extends under the margin of the liver, involving that organ secondarily. Although he has had no jaundice, he has at times exhibited a distinctly bilious appearance. He has that faint yellowish hue which is observed in some cases of slight jaundice. I show you a specimen of the urine passed a few minutes ago. Testing with nitric acid, it is found to contain the biliary coloring matters. In other words, the biliary function of the liver is disturbed, as is shown by the peculiar tint of the skin and the examination of the urine.

The surface of the body is cool, the pulse rather slow and the organs of circulation are in a fairly good condition, normal, for this period of life, so to speak.

We next come to the final point: What is the nature of this growth, and what is its relation to this obvious hepatic disturbance? When we consider the age of the subject, the great hardness of the mass, its rapid development and the great emaciation which it has produced, we can scarcely avoid concluding that we have to deal with malignant disease, most probably of the scirrhus variety. For the reasons which I have given, I think that the mass occupies the omentum, passes somewhat under the liver, with which it is probably connected by inflammatory adhesions—for he has had considerable acute pain—and that secondary deposits have taken place in the organ. We have then scirrhus of the omentum, with secondary deposit in the liver.

Such being the character of the case, what treatment should be pursued? Of course, if this diagnosis be correct, the treatment will occupy a very secondary position. In all cases of this kind, as I have told you on other occasions, we should not pronounce a fatal sentence, but should assume the existence of a curable disorder. I shall follow the beneficent rule in this case, and assume that we have a condition which can be remedied, and shall use that remedy which, above all others, has the power of affecting the absorption of inflammatory and specific exudations. I will, therefore, tentatively give massive doses of iodide of potassium, by way of beginning the treatment. By massive doses, I mean from twenty to forty grains three or four times a day. This is such a diffusible agent, that in order to make a profound impression, it must be given in large doses. I shall order for this patient half a drachm of iodide of potassium three times a day, well diluted with water, so as to give the stomach as little distress as possible. The patient also suffers from constipation, which should be relieved by enemata.

Topical applications would be of no service if the diagnosis which we have made be correct; but following out the beneficent rule, already laid down, I shall order the ointment of the red iodide of

mercury to be used once a day until the characteristic action on the skin is produced. I use this on account of its specific action, and because it unquestionably has the power of promoting absorption.

Another thing which should be done, as an aid to diagnosis, is to introduce into the mass an exploring trocar, and withdraw, if possible, some of its contents for microscopical examination. This would have been done before presenting him to you, but the man just came to the clinic. We shall, however, take an early opportunity to make the puncture. This can be done with perfect safety, and will probably settle the question as to the character of the growth.—*The Col. and Clin. Record.*

ADVICE TO MEDICAL WITNESSES.

In the transactions of the Oregon State Medical Society, will be found a paper on Forensic Medicine, by the President, Dr. C. C. Strong, of Portland, Oregon, from which we condense the following advice to physicians who may be called upon to give medical testimony in the course of a trial. First, let there be the most thorough preparation; the study of the case should be as complete as possible, as every opposing lawyer has "crammed" for the occasion, and will not fail to take advantage of the slightest slip in the testimony of the witness. It places a medical man in a very unpleasant position who comes into court from a half-performed post-mortem examination, satisfied because he has detected disease of the heart sufficient to cause death, if he is questioned whether or not there was fracture of the skull; and if subsequent examination or testimony reveals that condition, of which he was ignorant, he loses professional standing which can never be recovered. Let the preparation be methodical, and if possible, chronologically arrange the facts in the case. Be careful to refresh the memory just before the trial as regards places, dates, names, and times; and when possible in naming a particular day, in the course of the testimony, it is well to give the reasons which impressed it upon the mind. Consider carefully beforehand size, weight, distance, when these are involved, using invariably their old English standards in mentioning them; and where proximate measure only is required, be sure and refer to well known articles. There is nothing impressive, but the contrary, in referring to some professional standard generally unknown to the laity, unless it is necessary to make the testimony clear. If the witness is able to make some kind of a sketch showing the relation of a body, or portion of one, to its surroundings, his words can be much more plainly and definitely understood—but the sketch must be absolutely accurate.

As an expert the physician will frequently be

called upon for his opinion, and as his conclusions are to be deduced from proven facts, they must be carefully drawn to possess any value. To perform this duty thoroughly he should therefore not wait until in the witness box. Tidy's advice may well apply at this point. He says: "And if in the quiet of your study you fail to come to a satisfactory conclusion, do not attempt a wild conjecture in the hurry and excitement of the witness box. To be accurate is ten thousand times better than to appear brilliant." The physician should carefully study the opinions held and expressed by others, and be able to give good definite reasons why he adopts some and rejects others, always remembering he will be exposed to the scathing fire of cross-examination. He should bear in mind the difference between a fact and an opinion so that there may be no confusion in his mind regarding their identity. For example, it is a fact that certain drugs are deadly poisons; but their action in producing certain effects is an opinion. The direction, size and character of a wound are facts. Deductions drawn as to the manner in which the wound was produced, or for what purpose, is, in most cases, a matter of opinion. An opinion, however, is always based on facts, and either a personal knowledge of the circumstances relating to these facts, or knowledge gained from undisputed authority concerning them, is essential. No tolerance can be given to hearsay or rumor. A biased statement given by a witness is invariably detected, and attempt of the witness to arrogate to himself any of the duties of the jury, injures the value of his evidence. The plainest English should be employed, and any tendency to exaggeration suppressed. Be sure before answering that the entire question is thoroughly understood, and the question alone asked should be answered without ambiguity or useless expressions. All "ifs" and "thats" should be omitted if possible, and the answers should convey real meaning in such clear, unmistakable language that there can be no misunderstanding. If no distinct opinion on a certain subject has been formed, there should be no hesitation in saying so; and the physician should never allow himself to be drawn into, or give, an opinion formed on the spur of the moment, in the witness box. As nearly as possible the exact language of conversations testified to, or authorities quoted, should be given. When the close pressure of cross-examination occurs, the only safety of the witness is in coolness, self-possession, and a thorough knowledge of the case. If he lose his temper, he is sure to be led on until he irretrievably damages himself, his testimony, or his medical reputation. Admitted ignorance of a question not understood is not only not condemnatory, but praiseworthy; and within certain limits the answer, "I do not know" is both safe and honorable. A witness may be obliged to answer yes or no in a

given case; but, though he may not modify it, he has a right to explain his answer so as to make it comprehensible, and he should always avail himself of that privilege, to prevent any chance of a misunderstanding of his meaning. All facts should be given as the witness understands them, without reference as to their effect, and in opinions drawn from facts if any honest doubts arise, they should be plainly stated.

The witness should never allow himself to be drawn into a discussion; but having given an opinion, and the reason for it, let it rest there. He is entitled to have the question fairly and clearly stated to him; and the utmost care is required that the conditions of a hypothetical case should be plainly discerned and properly understood by him before answering. If the hypothetical case contains impossibilities, or inconsistencies, he should never endeavor to give a mixed answer, but insist that a proper case be given him. One of the most important points of all to be remembered is, that the opposing attorney will probably attempt to impair the value of important testimony given by the medical witness, by showing lack of professional knowledge, and will propound questions which are incapable of definite answers, because of differences of opinion among high medical and legal authorities. The only manner by which such an attack can be met is to enter the courtroom prepared to state the existence of such differences, when they exist, and as they will probably relate either in a direct or remote manner to the subject of trial, the simple form of preparation is that recommended by Tidy, namely, get the case well up in your office before the trial.

NEUROSES OF THE VISCERA.—Dr. Clifford Allbutt in the Gulstonian lectures gives the following:—If we turn our eyes upon the flock of women who lie under the wand of the gynæcologist, we shall find it so largely composed of the neurotic and hysteric, that we may say in our haste the uterus has no substantial diseases; that its affections are all neurotic, or so far reinforced by neurosis as to depend for their cure mainly upon neuropathic medicine. Herein we in our turn should be to blame. Many a woman, otherwise robust enough, and many a woman, whose weakness may lie not in her nervous system, suffers from uterine disorder, from painful uterine states, nay, even from distant sympathetic pains also, which come of mischief wholly local, or of mischief reinforced by diatheses other than the neurotic. Making however, the utmost allowance for all these, I contend that a vast number, I will go further, and say a preponderating number, of such sufferers lie under the scourge of neurosis, and that their uterine and ovarian disorders are either wholly neurotic, or, as I have said, so reinforced by neurosis as to depend chiefly or wholly upon general medicine.

Let me take as an instance a young lady coming of a family in which great mental gifts had thrown into relief the many eccentricities and humours which accompany them; a family, too, of which no household had been free from nervous disease. She possessed the gifts and the attractions of the neurotic diathesis, and labored under its defects. It is possible also that she was in some degree under the stress of what Anstie called the unconscious sexual impulse. She was restless, excitable, and suffering. Her pains were mostly pelvic and abdominal. She never put her feet to the ground, partly because it intensified her pain, partly because she had been forbidden to do so. She had lain on her back for months. Pessaries had been introduced, but, being intolerable to her, were withdrawn. Her periods were agonizingly painful for the first two days, and were profuse, and she had constant leucorrhœa. Her appetite was almost gone, her stomach queasy, her frame emaciated; but she was unselfish and full of courage, and would have scorned the wiles and exacting whims of hysteria. Her womb had been incessantly under specular and other examination for a year or two, and, like nearly all such patients, she had uterus on the brain. I found the vagina tender, and the womb exquisitely tender; its substance was soft, and its attachments lax. Its position, therefore, was somewhat backward and downward. Acute suffering was caused in the upper hypogastrium when the fundus of the uterus was pressed upon *per rectum*. The rectum was full of feces. By the speculum, I noted that there was both uterine and vaginal catarrh, and that the os uteri was excoriated—in the state, that is, of the upper lip of a scrofulous and snivelling little boy.

My most difficult task was to win my patient over to the belief that her disease was not mainly uterine, but mainly neuralgic; this once accomplished, our progress, though slow, was sure. I declined to initiate any treatment whatever until she would get her feet to the ground, and thenceforth cautiously regain the use of her legs. This took three months. Meanwhile I declined to “cure the ulceration of the womb” for the twentieth time, but made her content with rectal and vaginal astringent douches, first hot and afterward cold. As soon as she could walk, we perched her upon horseback. She was treated with the phosphide and valerianate of zinc, with bromide of ammonium, iron, quinine, and like remedies, with occasional sedative suppositories. In six months I found the uterus more compact, the ligaments braced, and the os clean and sound; the leucorrhœa had ceased, and all the parts could be handled without pain. Menstruation was still painful, but less so than formerly, and there was some menorrhagia. She was mixing, however, in general society, could ride gently to hounds, had regained appetite and looks; and, although I then lost sight of her, I

have every reason to suppose she is as well as she is ever likely to become.

REMARKS ON CHOLERA INFANTUM.—Dr. James Craig, Jersey City, N. J. (*Archives of Pediatrics*) says:—During the summer months the mortality among children is alarming, and calls for the earnest attention of medical men. The extreme heat and enervating character of our climate tend to exhaust and induce a nervous condition of the system, and when attacking the digestive organs produce a specific diarrhœa, well named cholera infantum. Its course in some cases is very rapid, and in all dangerous, if not soon relieved. The watery evacuations produce a thickened condition of the blood, interfering with free circulation, causing passive congestion of the brain, and adding another danger, viz., compression from effusion of serum into the ventricles, producing convulsions, and in some cases coma and death.

Convulsions, also, are caused by reflex action from irritation of the stomach and bowels. In some cases the stools are very frequent, with an odor *sui generis*, which is almost pathognomonic of the disease; in other cases, there may be very few movements, but very large in quantity, and when such is the case may there not be a septic influence at work poisoning the blood and overwhelming the system? Cleanliness should be rigidly observed, and the stools removed as soon as voided. Vomiting, or the effort to do so, is a very distressing symptom, and demands prompt attention.

The treatment of cholera infantum varies very much, and depends upon the physician's ideas and experience. The indications are to prevent nausea and vomiting, support the strength, and check the diarrhœa. If nursing, no change in diet is made, but care should be taken not to nurse the child too often or too much at a time. If bottle-fed the milk is stopped, and stale bread, soaked in water with a little sugar and brandy added, or Robinson's prepared barley, or arrow-root made with water, and given in small quantities answers a good purpose. Milk is also prohibited where the child is weaned, but is gradually resumed as it improves; where the child is weak, one teaspoonful of brandy to six or seven of water, a teaspoonful of which is occasionally given. Where a more powerful stimulant is required, carbonate of ammonia in one or two grain doses mixed in syrup of acacia is used according to the age of the child.

For the gastric and intestinal derangement my favorite prescription, is:

R Liq. Acidi Carbolici, 5 per cent,.....3j;
 Bismuthi Subcarb.,..... } aa 3j;
 Pepsini sacch.,..... }
 Syr. Aurantii cort.,.....3ij;
 Aq. Cinnamomi, ad.....3iij;

M. Sig.: A teaspoonful every two or three hours until relieved.

I also apply a spice plaster over the abdomen composed of the following: Powdered cinnamon, cloves, nutmeg, ginger, allspice, of each, two drams; honey and glycerine, of each, four drams; white of one egg, and spread on cheese cloth or fine mosquito netting. It may remain on over the region of the stomach and bowels for hours or days without blistering; it merely reddens the skin, and is an excellent counter-irritant. A bandage should be applied over it to keep it in place.

Change of air frequently brings about convalescence in a very short time. When that cannot be had, the next best thing is to take the child out daily for an hour or two at a time early in the morning and late in the afternoon. While in the house the child should be kept in a well ventilated room, free from draughts.

USE OF FORCEPS IN BREECH PRESENTATIONS.—Dr. Truzzi is strongly in favour of the use of forceps in breech presentations. He says that, in cases of impaction of the breech in the upper or middle parts of the pelvic cavity, the prompt extraction of the fetus being indicated, and while one of the hips is not yet rotated under the arch of the pubes, it is better to have recourse to the application of the forceps to the fetal pelvis than to trust to traction on the groins, which is insufficient if practiced with the fingers, and dangerous with the blunt hook or fillet. The proposal of Clivier to apply the forceps on the thighs rather than to the pelvis of the fetus, though seductive theoretically, does not work practically. It is difficult to limit the pressure of the forceps to the thighs alone; and if this be not done the abdomen would be pressed on, and possibly even the liver injured. The concave extremities of the forceps pressing on the convex surface of the thighs, slip downwards and forwards, and after a few pulls the original good hold is lost. Much easier and safer is the plan of applying the forceps to the side of the fetal pelvis. The iliac bones at this period are so elastic, and, compared with the bones of the head, are so protected by the soft parts, that even if the force of compression be somewhat abused, it is difficult to injure the fetal pelvis. To obtain a firm hold, the extremities of the blades must be passed beyond the crests of the ilia, and when the handles are approximated they bury themselves slightly in the walls of the abdomen, and on traction being applied, bear on the crests of the ilia, and at the same time impart to the hips of the fetus a convexity to which the concavity of the blades of the forceps exactly adapts itself. The liver runs no risk since, large as it is in the fetus, it never descends to the level of the crest of the ilium; besides, its lowest part is the thin edge of the right lobe, which may be displaced inwards, but not lacerated or contused by pressure of the forceps. The same may be said of the intestine,

which from its mobility avoids even the consequences of considerable pressure if this be made in a methodical and skilful manner. A folded cloth may be placed, as suggested by Tarnier, between the handles of the forceps, to prevent too much compression. The forceps takes a better hold, and the author has never seen it slip in sacro-posterior positions. He recommends, in some cases of sacro-posterior positions, that the position should be altered by a forcible rotation of the sacrum forwards before using traction. It is better, he says, to keep up a certain amount of compression in the intervals of traction; if this be not done, the iliac wings, by their great elasticity, tend to resume their normal place, and the forceps may be displaced.—*Lon. Med. Record.*

CHRONIC BRIGHT'S DISEASE.—Dr. Wm. Pepper (*Medical Times*, April 19, 1884,) gives the following in regard to treatment:

"With this pulmonary trouble and emaciation, I should be unwilling to treat her with such a rigid diet as I should resort to if she were in a better state of nutrition, and were not the subject of chronic lung disease. She will receive a light breakfast and supper, consisting of some form of mush, with cream or milk. Her dinner will consist of meat, fish, or oysters. Between each meal she will be given a glass of milk; egg will be avoided. The form of albumen found in eggs has seemed to me to dispose to an increased excretion of albumen. I prefer to this lean, under-done meats and oysters.

"I propose to give her cod-liver oil and bichloride of mercury. Iodide of potassium, which I should gladly give her occasionally, irritates the kidneys. I therefore prefer to use bichloride of mercury, beginning with a moderate dose and increasing it as the stomach will permit. I shall commence with one-fiftieth of a grain, slowly increasing to one-twentieth of a grain, immediately after meals. The cod-liver oil will be given during the alkaline stage of digestion, an hour and a half after meals. Iodine will be applied over the left chest as frequently as can be done without producing too much irritation of the skin. The action of the skin will be promoted by daily friction and the rubbing of a little oil into the skin."

ANEURISM—LACERATION—PROLAPSUS UTERI.—M. Trélat communicated two cases of aneurism to the Société de Chirurgie, one of which refused to be influenced by indirect pressure sustained for a relatively long period. The position occupied by the tumor was the popliteal space, and although compression was made in Scarpa's triangle, no diminution was appreciable. At last the ligature was resorted to, and the tumor was not slow to shrink, harden and disappear. The same member reported a case of suture of the perineum, in which

the perineal and vaginal sutures were made. The patient cured rapidly. Out of eleven cases thus operated upon, only three failed. M. Verneuil, who agreed with M. Trélat as to the position of the sutures, preferred the silver wire to the mother-of-pearl buttons; he leaves them eight or ten days *in situ*. M. Després was astonished at the large number of these cases which have recently come to light. In his long career he had only three times practiced the operation. His principle was to wait until three months after the delivery; and to prevent the vaginal liquids from penetrating the wound, he made the patient lie upon her face.

M. Thomas communicated the case of an irreducible prolapsus of the uterus, and for which he was compelled to have recourse to total ablation by the elastic ligature. It was the case of a domestic, who for two years had been suffering from the affection in question, and all attempts at reduction were rendered useless. The tumor was voluminous, and showed signs of sphacelating. In an attempt at reduction he tore the posterior wall of the vagina. It was then he decided on extirpation, and the patient made a good recovery.—*Medical Press.*

ELECTRICITY IN PARALYSIS CAUSED BY CEREBRAL HEMORRHAGE.—Authorities differ greatly as to the time which should elapse after an apoplectic attack has been followed by paralysis, before commencing treatment by electricity. The general opinion is in favour of allowing some time to pass, so as to permit the absorption of the clot and the subsidence of the inflammatory reaction. Prof. De Renzi (*Revista Clinicae Therapeutica*, Jan., 1884) on the other hand, thinks that electricity may be employed, if proper precautions are taken, with the greatest success a short time after the attack, that is, in the first week. To the treatment of electricity he invariably adds other means to prevent the return of the hemorrhage and the development of inflammatory reaction. These consist in the external use of bromide of potassium, the constant application of cold to the head, and the administration of some drastic purgative whenever there is constipation. The application of electricity exerts an immediate effect on the muscles, which, in the majority of cases, at once regain their contractile power under the influence of the will. S. P. was admitted suffering from cerebral hemorrhage; on the fourth day of the attack there was complete paralysis of the left leg. Electricity was applied to the muscles of the thigh, and immediately afterwards the patient was able to bend the limb and to raise the knee for some distance from the level of the bed. On the next day the patient was unable to extend the limb after bending it; electricity was again applied; he then flexed and extended the leg without difficulty. On the sixth day paralysis of the toes only remained,

and this also yielded to electricity. The application of electricity ought to be practised directly the rapid and spontaneous disappearance of the paralytic phenomena, which is usually noticed in the first days after an attack of apoplexy, is arrested. The intensity of the current should be very little, and such that it can hardly be perceived by the observer, touching the rheophores with his fingers wetted in salt water. The interruption of the current must be considerable, the greatest that can be obtained with the automatic interrupting apparatus of the electrical machine. The electrical excitement must be limited to the muscles and intramuscular nerves, therefore the two rheophores must be applied successively for a few seconds to the fleshy parts of the various muscles. The duration of each application is from one to several minutes. The instantaneous action of electricity in paralysis from cerebral hemorrhage is easily explained by admitting that these paralyzes are often neurolytic or suspensive, and that they do not depend on destruction of nerve elements. The electricity induces in the nerves a negative variation, which extends to the two extremities of the nerve-fibre; so that it overcomes the state of neurolysis determined at the central extremity of the same fibres by the extravasation of blood.—*London Medical Record*.

DIGITAL DILATATION OF THE OS.—At a meeting of the Obstetrical Society of Philadelphia, held April 3rd, 1884, Professor Theophilus Parvin expressed the following views on this subject, while discussing a paper:

He would be sorry to see digital dilatation adopted as a rule for all cases. The fingers, used as recommended, did not act solely, possibly not chiefly, as dilators but evoked uterine contractions. Voluntary efforts at bearing down were not needed during the first stage; they were dangerous rather than helpful. The method might be useful in some cases after the rupture of the bag of waters, which was the natural dilating agent. There was also danger of septicæmia from germs on the fingers. He did not think the finger so good a dilator as Barnes' dilator, because unequal, partial pressure upon the os did not evoke the decided uterine contractions that uniform pressure did. He thought the danger of a change of presentation by the use of Barnes' dilator was very slight. He would prefer a mechanical dilator to the finger whenever dilatation was necessary, but thought something ought to be left for nature. Any sort of interference involved a possibility of danger.—*Col. and Clin. Record*.

ORAL PATHOLOGY.—A red line on the gums, with fetor and metallic taste, indicates pytalism, a blue line, lead poisoning; great sponginess, with sloughing and great fetor, scurvy; a red line about

the teeth and along the gums, periostitis; purple gums and purulent discharge, necrosis; gums hot, red, swollen, very tense, phlegmon; gums inflamed and soft, with fluctuations, alveolar abscess; swollen gums, fetid discharge, mucous patches, shallow ulcers under the tongue, eroded palate, eruption of mouth, skin and scalp, gums everted, fetid matter from necks of teeth, syphilis; a white coated tongue, indigestion; a brown, dry tongue, depression, blood-poisoning, typhoid fever; a red, dry tongue, inflammatory fever; a red, glazed tongue, general fever, loss of digestion; a tremulous, moist and flabby tongue, feebleness, nervousness; a glazed tongue, with blue appearance, tertiary syphilis.—*Independent Practitioner*.

SPERMATORRHEA.—A mixture containing tincture of perchloride of iron and tincture of nuxvomica should be given twice or three times a day; also a pill containing a fourth or a third of a grain of extract of belladonna with three grains of camphor, should be given at first, every night immediately before going to bed. If these lines of treatment be adhered to, the patient, whether suffering from real spermatorrhœa or simply from frequently returning nocturnal emissions will be greatly relieved. The emissions will occur less and less frequently, till, in the course of a few weeks, or possibly months—for a malady of long standing (as this usually is) is never cured immediately—they will cease altogether, or only occur at such intervals as may be deemed normal, and in which there is no harm whatever.—*Brit. Med. Jour.*

SUBUNGUAL EXOSTOSIS.—(*Gaz. med de Nantes*.) M. Heurtaux exhibited a subungual exostosis of the right big toe, which he had removed from a lad of 15. The first manifestation of this tumor was about a year ago. At first, pains were only slight, but the wearing of boots became very painful. Three or four months later, the nail was raised, then perforated as of excessive usage. Pain became unbearable; the exostosis was the size of a hazelnut. In order to remove it, the nail had to be extirpated first, a horny layer which covered it had to be detached; then a hollow gouge was plunged in it obliquely, and by this means the tumor was lifted out.—*St. Louis Med. and Sur. Jour.*

SULPHATE OF IRON IN THE TREATMENT OF HEMORRHOIDS AND PROCTOCELE.—Dr. Wimpellberg recommends an ointment of the subsulphate, in the proportion of 12 grains to the ounce, to be applied night and morning. In cases of proctoceles, he uses the persalt internally, in doses of 2 gr. three times a day, in conjunction with the local use of the ointment. He speaks particularly of the rapidity with which he has known piles to disappear under this treatment during pregnancy.—*Medical Bulletin*.

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
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RESTRICTION OF NOSTRUMS.

The adulteration of articles of food is held to be a crime against public health and morals, and all enlightened governments have enacted laws declaring such practices illegal, and ordering persons guilty of them to be punished by fines and imprisonment. However imperfectly such laws may be obeyed their universal approval is undoubted. In all this we see the principle acknowledged that the people need to be protected against imposture; and not only so, but protected against themselves. This is freely conceded by the press and the legislature in this and every enlightened country. It is not until we enter the domain of medicine that the principle meets with opposition. Let it be hinted that the people need to be protected against charlatans and nostrum vendors, and a loud chorus of opposition arises from thousands who are advocates of restrictive laws as applied to food and drink. They admit the right of the State, within certain bounds, to declare it unlawful to manufacture or sell certain articles of food or drink, but deny the right of the State in any way to circumscribe the liberty of the subject in the matter of medicine. This is not logical; it is not common sense. The reverse would be nearer the correct view, since the people generally are far better judges of the quality of food and drink, and their effects, than they are of medicines. Moreover, the laws regulating food and drink have regard, for the most part, to the physically strong and mentally sound, a class ordinarily capable of protecting themselves, while laws regulating the sale of

medicines and nostrums, have regard, for the most part, to those who are physically weak, and incapacitated for correct and impartial judgment, from the effects of disease. If any class in the community need to be protected it is those labouring under the physical and mental debility induced by disease. They are the easy prey of every form of medical imposture which promises relief from their maladies. The ordinary layman readily sees the necessity of punishing the man who practices fraud in the matter of his beef-steak, or his ale, but when it comes to guaranteeing that he shall not be injured by the medicine he takes, he does not so readily see the force of the argument.

Happily in this, as in nearly every other civilized country, the law requires that those who undertake to cure disease shall be educated and skilled in their calling—not but there are those who would readily break down the barriers erected against charlatanry. Even in this country, and in this day of high intelligence, we have in our midst those who are willing, nay anxious, to expose the weak and suffering amongst us to the rapacity of the quack and the nostrum vendor. So far as the law can do it the quack is kept at bay, but the patent medicine vendor has full liberty to ply his calling. That he makes good use of his opportunities no one will deny. The vast amount of capital employed, the enormous sums spent on advertising, and the large stocks everywhere exposed for sale, are sure evidences of a thriving trade. It is appalling to contemplate the evils resulting from this cause. There is first the diversion and misapplication of capital and energy. Some faint idea of the extent of this business may be formed from a consideration of the figures furnished in a memorial to the U. S. Congress, presented by the patent medicine men in 1882. In the U. S. there is an internal revenue tax of from 8 to 10 per cent. on manufacturers' prices. This tax yielded nearly two millions of dollars in 1882. From this we learn that the volume of business done by the manufacturers in that year amounted to about \$24,000,000, and if to this be added the profits of the wholesale and retail dealers it will represent double this amount. Frauds on the revenue, and all taken into account, the annual cost of patent medicines to the people of the United States cannot fall much short of \$50,000,000. From the same memorial we learn that the patent medicine men

paid the press in twenty years, most of it within the last few years, no less than \$100,000,000. To show the princely way in which the patent medicine men subsidize the press, secular and religious, and thus give newspaper men an interest in the trade, we may mention that Vogler & Co., the St. Jacob's Oil men, spent in this way, \$400,000 in one year. A glance at the columns of any leading newspaper is sufficient evidence of the truth of this statement. It is no secret that the revenue derived by the press from this source is very large, and rapidly increasing. Under such circumstances it would be folly to look to the press for aid in a movement having in view the curtailment of this traffic, or its regulation within certain bounds.

The most unreasoning will not contend that even a tenth part of these millions is obtained for value received. These vast revenues are obtained by misrepresentations and exaggerated statements regarding the efficacy of the nostrums in question. Worse than all, the money is filched from the pockets of the sick and suffering, most of whom are too poor to provide themselves with needful food and clothing, yet are induced to invest in these vile compounds in the vain hope of realizing the promises of cure held forth in the attractive patent medicine literature scattered broadcast throughout the land in the form of almanacs, pamphlets, advertisements, and entertaining articles on other topics spiced with particular nostrums which now adorn the pages of every newspaper. This traffic not only robs the poor and the sick but destroys life as well. A rich syndicate—for this is the modern way of "booming" a nostrum—obtains possession of the columns of every influential newspaper on the continent. Able writers are employed, and the remedy is dished up to us whether we have ordered it or not, in the shape of reading articles, and every newspaper reader is compelled to swallow the nauseous dose. History records many infamous swindles, such as the Holland Ruses, and the South Sea Bubble, but the patent medicine humbug is the most gigantic and inhuman the world ever witnessed.

THE ONTARIO MEDICAL ASSOCIATION.

The fourth annual meeting of the Ontario Medical Association, which took place in Hamilton on the 4th and 5th ult., under the presidency of Dr.

Clarke, of Toronto, was a most successful gathering. Although a comparatively young association, it gives evidence of great vigor and a long career of usefulness. The papers read were numerous, varied, and of more than ordinary merit. The discussions which followed were in most cases interesting and instructive. But in view of the increasing number of valuable papers presented from year to year, we think it would be advisable to extend the time of the meeting to three days instead of two, as the time is rather short to do justice to all. Some important papers and reports are left over every year from want of time to read and discuss them. This is not only most undesirable in itself, but also most discouraging to those who spend much time and labor in the preparation of papers and reports. With regard to the next place of meeting, although in principle opposed to the peripatetic system, we are pleased that London has been the place chosen for next year's meeting, and sincerely hope that our confrères in the "Banner city of the West" and surrounding country will bestir themselves so as to make the meeting a great success, far outstripping any of the previous ones. In future, however, we hope to see Toronto become the fixed place of meeting. It is confidently expected that the Medical Council will have the new College buildings erected by that time, or at all events very shortly, and as it is the intention to establish a pathological museum in connection therewith, this will be the most suitable place for the meetings of the Association.

The papers read at the meeting will be published from month to month in the Toronto medical journals and will no doubt be read with interest by the profession generally. An important change has been made in regard to the work of the committees on medicine, surgery, etc. In accordance with a resolution passed at the last meeting, the chairman of each committee will read a paper and open the discussion on some previously selected subject, instead of presenting, as formerly, a comprehensive report which was almost invariably taken as read, owing to its inordinate length. This is an improvement in the right direction and one which, if properly understood and acted upon, will give zest to the work. Dr. Addison Worthington, of Clinton, was chosen president, and the next meeting, as above stated, will be held in London on the first Wednesday and Thursday in June, 1885.

The following committees have been struck by the President. In our next issue we will be able to give the subjects selected in Medicine, Surgery and Obstetrics, and also the names of those who will lead the discussions in each, in accordance with the plan determined upon at the last meeting.

Standing Committees.—To be added to the Committee on Credentials—Drs. Caw, Parkhill; and Griffin, Brantford. Nominations—Drs. Aylesworth, Collingwood; Richardson, Toronto; Ridley, Hamilton; and Harrison, Selkirk. Public Health, etc.—Drs. Ryal and Shaw, Hamilton; McKinnon, Guelph; and Fraser, Sarnia. Legislation—Drs. Leslie and Hillyer, Hamilton; Hunt, Clarksburg; and McMahon, Dundas. Publication—Dr. Fulton, Toronto. By-laws—Drs. Potts, Cobourg; Battersby, Port Dover; and Thrall, Woodstock. Medical Ethics—Drs. Biggar, Hamilton; Howitt, Guelph; and O'Reilly, Toronto.

Temporary Committees.—Surgery—Drs. Powell, Edgar (Chairman); Malloch, Hamilton; McFarlane, Toronto; Groves, Fergus; Bray, Chatham. Medicine—Drs. Tye, Chatham (Chairman); Mullin, Hamilton; Graham, Toronto; Carney, Windsor; C. K. Clarke, Kingston; Phillip, Brantford. Obstetrics—Drs. Temple, Toronto (Chairman); Holmes, Chatham; Harris, Brantford; Rosebrugh, Hamilton; A. A. Macdonald, Toronto; Gunn, Brucefield. Ophthalmology and Otology—Drs. Ryerson (Chairman), Reeve, Burnham, Rosebrugh and Palmer, of Toronto. Necrology—Drs. Kitchen, St. George (Chairman); Hillary, Aurora; Aikman, Collingwood. Audit—Drs. McKay, Woodstock (Chairman); Miller, Hamilton. Papers and Business—Drs. Hutchinson, Brussels (Chairman); McLean, Goderich; Anderson, Winchester Springs; Baines, Geo. Wright and Nevitt, of Toronto. Arrangements—Drs. Arnott, London (Chairman); Wishart, Edwards and Moorehouse, London; Fairchild, Burford; Tisdale, Lynedock and Porter, Walkerton.

Among the exhibitors, the firm of Reid & Carnrick, of New York, was ably represented by Mr. Gisborne, of Toronto, with a full supply of their valuable pharmaceutical preparations, maltine, lactopeptine, etc. Mr. Stevens, of Toronto, exhibited a great variety of surgical instruments and appliances, and also the use of the electric light as applied to laryngoscopy. The latter instrument attracted considerable attention.

THE ONTARIO MEDICAL COUNCIL.

The annual meeting of the Ontario Medical Council was held in Toronto on the 10th of June and following days, under the presidency of Dr. Day, of Trenton. This was the last meeting of the present Council prior to the elections, which will take place in May, 1885. The proceedings of the Council were transacted very quietly and in a most business-like manner, the great bulk of the work being done in committees. Some very important recommendations were made by the Committee on Legislation, with reference to certain amendments to the Medical Act. Among these may be mentioned the insertion of a clause giving the Council power and authority to discipline the members of the College who may be found guilty of unprofessional conduct. This power seems to be greatly needed, in view of the fact that certain members of the College have so far forgotten what is due to their honorable calling as to hire themselves to peripatetic quacks and imposters to do professional work in this Province from which the latter were debarred by the Act. Another proposed amendment provides that the annual membership fee be raised to \$5, which may be commuted by a life payment of \$20, or in case of those who have paid their annual dues regularly, \$20—less the amount previously paid. This will be considered a great relief, as most members will no doubt prefer to pay the commutation rate, rather than have the worry of sending a small remittance every year. The clause which proposes to give the Council power to appoint a medical practitioner in each electoral division, to tax all medical bills in dispute, with powers similar to the taxing master in Chancery, is a move in the right direction and will, if made law, be the means of preventing many vexatious lawsuits. Last, but not least, is a clause which provides that schools and colleges without a teaching faculty shall not be admitted to representation in the Council. It has been universally felt that the college and school men in the Council were out of all proportion to the Territorial representatives, and as a means of getting over the difficulty, it was at one time proposed to double the number of Territorial representatives; but this was objected to on the ground that such a measure would largely increase the expenditure. If, however, by this enactment a number

of the college men are swept away, the representatives will be more evenly balanced.

A few unimportant changes have been made in the curriculum, which will come into force after June, 1885. One of these has reference to graduates in arts, who were formerly allowed one year's time in the medical course. This regulation was originally intended to give encouragement to young men to take an arts course prior to entering the study of medicine, and was in our opinion a very wise provision. We would therefore regret very much to see the above-named change carried into effect.

JAMES JOHN DICKINSON, M.D.

The subject of the following sketch, whose death occurred on the 10th of May, was born in Cornwall, Ont., in the year 1819. He was the son of Noah Dickinson, M.D., who was a pioneer and a member of an old family of U. E. Loyalists. He received his early education in the famous Grammar school of the town. On arriving at his majority he joined the active militia, in which he served seven years, rising to the rank of ensign. He was present at the battle of Windmill Point and other engagements. In 1842 he began the study of medicine in McGill University, where he graduated in 1846. He at once volunteered to go to Grosse Isle in attendance upon the *ship fever* patients. In the autumn of 1847 he returned to Cornwall, commenced practice, and in 1850 married the daughter of the late Rev. Dr. Mountain, rector of Trinity church.

Dr. Dickinson never lost sight of his attachment to the military service, to which the years of youth were devoted. He organized and for years commanded a troop of yeoman cavalry, of which he was Major, entitling him to the rank of Lieut.-Col. in the militia. He was for two years Reeve of Cornwall, was always a staunch Conservative and a respected brother of the Masonic Order, his remains being interred with the honors of the craft. Dr. Dickinson remained in the active practice of his profession up to the close of 1879, at which time he handed over many of his responsibilities to his partner, C. J. Hamilton, M.D., of Goderich, who subsequently became his son-in-law and who has now succeeded to his extensive practice. Like all men of fearless temperament, Dr. Dickinson

acquired many pronounced enemies, as he did hosts of admiring friends. He was a leader in his profession and an ornament to it, and his death is deeply regretted by all who knew him, professionally or socially.

ROBERT STEPHEN, M.D.

We very much regret to announce the death of Dr. Robert Stephen, of Digby, N.S., on the 20th of April, at the age of 76 years. Dr. Stephen was born in Elgin, Scotland, and emigrated to Canada in 1835. He attended lectures in the Royal College of Surgeons, Dublin, and was soon after appointed surgeon to one of Sir Alexander Bannerman's ships during a voyage of two years to the Arctic Ocean. On his return he practised a short time in Elgin, prior to his emigration to this country. At the solicitation of a number of the inhabitants, through the late James H. FitzRandolph, he settled in Digby, where he continued to practise his profession up to the time of his death. He was a member of the Nova Scotia Medical Society and coroner of the county of Digby for the past thirty years. During the long course of his professional life he had outlived all his early contemporaries, and had acquired a host of friends, who well appreciated the native kindness which underlaid his apparently brusque demeanor. Firm and decided in his opinions and views, he fearlessly maintained what he considered was the right, with all the energy of his character. Deceased was the father of R. W. Stephen, Esq., of the Senate Staff, Ottawa.

SODIUM SALICYLATE IN UTERINE AFFECTIONS.—M. Balette, in an article on this subject in *Bull. Gen. de Thérap.*, states that this remedy in ordinary doses allays the pains of dysmenorrhœa, probably by its sedative action on the central nervous system. It also promotes the menstrual flow, and in some cases provokes its re-appearance. In four instances, in large doses, it was followed by abortion, but moderate doses seem to have no tendency to act as an abortifacient. No oxytocic effect was ever observed in experiments on animals. Nevertheless, the caution is added that it should never be given during gestation, except on very precise

indications, and that then its action should be watched carefully.

CURABILITY OF LOCOMOTOR ATAXY.—In a recent number of *La France Médicale*, Prof. Eulenburg states that of 300 cases, he has known only three cures, but thinks the percentage might be increased by more assiduous treatment. He regards nitrate of silver as the remedy *par excellence*, but thinks it is inert when given in pill, and recommends subcutaneous injection in the form of the hyposulphite or albuminate. He uses the following.

R—Chloride of silver,	grs. iss.
Hyposulphite of sodium,	grs. ix.
Distilled water,	℥ v.

Five to fifteen minims are to be injected daily in the dorsal region. Cold compresses are recommended to relieve the pains, and the use of the continuous current is also advised.

CROTON-CHLORAL IN WHOOPING-COUGH.—Dr. Moore, of Brockville, Ont., has been using this remedy for the past eight years in the treatment of whooping-cough, with the most gratifying results. In ninety-five per cent. of the cases in which he has used it, the disease was cured in from six to twelve days. He found it act equally well, no matter what the age was. It must be given in full doses, properly dissolved, and every three hours. His method of prescribing it is as follows. For a child from eight to ten years of age :

R—Croton-chloral hyd.,	℥ iiss.
Aqua bullientis ad.,	℥ viij.—M.

Sig.—℥ ss. every three hours, night and day.

The above dose, of course, should be increased or lessened, according to the strength and age of the patient. He says croton-chloral has proved as sure a specific in his hands, in whooping-cough, as quinine has in intermittents.

GONORRHOEAL RHEUMATISM.—Struppi (*Centralblatt für Chirurg*) has investigated eight cases of gonorrhœal rheumatism. He finds that it only occurs as a complication when the primary disease has passed the compressor urethræ and involves the prostatic portion of the urethra. The indications of treatment are to prevent the extension of the disease to the prostatic portion of the urethra. The author also recommends rest in bed, cold applications, low diet, and the administration two or

three times a day of five or six grammes of salicylate of soda, and friction of the joint, after pain has disappeared, with glycerin solutions of iodine and iodide of potassium.

MOVABLE KNEE-JOINT AFTER EXCISION.—In the London *Lancet* for May 17th will be found the report of a case of excision of the knee-joint by Dr. Boutflower of the Salford Royal Hospital, in which the joint motion was complete, notwithstanding the fact that a considerable section of bone had been removed from the femur and tibia, as well as the entire removal of the patella. The patient was 7 years of age, thin, anæmic and of a strumous habit. The limb was put up on a Watson's splint under Listerian precautions, and retained until the 21st day, when a plaster-of-Paris bandage was applied. The wound was entirely healed on the 14th day.

CASES OF MALPRACTICE.—The editor of the *Pacific Med. Journal*, in an article on the above subject, says : "We regard it as one of the first duties of physicians to each other, to defend one another as far as possible against charges of malpractice, which, even if more or less true, are likely to involve errors of judgment only ; to conceal the errors of others as they would their own ; to keep in strict privacy all personal difficulties ; and in most instances to avoid the exposure of dissenting opinions on professional questions relating to patients." We fully endorse the sentiments herein expressed by our worthy confrere of the Pacific.

TREATMENT OF HÆMOPTYSIS.—Dr. Taylor, of the North London Hospital, for consumption discusses the treatment of hæmoptysis in the *Lancet* of June 14th. He prefers warm applications to the chest, instead of ice, as usually practiced. He applies hot flannels (120° F.) over the angles of the ribs from summit to base, *i. e.* over the sympathetic ganglia. Internally he regards opium or morphine hypodermically as the most useful drug. If opium is contraindicated he then prefers oil of turpentine and fluid extract of ergot, the former by the mouth and the latter by the mouth or hypodermically.

SMALL-POX EPIDEMIC IN LONDON.—Our British exchanges state that the small-pox epidemic in London is assuming large proportions, and the ad-

missions into the hospitals, for the reception of infectious cases, are increasing in number. In the East-end the spread of the disease has necessitated the adoption of special precautionary measures, and Dr. O'Connor, the medical superintendent of St. George-in-the-East Infirmary, has suspended the usual visiting privilege to patients' friends during the small-pox epidemic.

THE BRITISH MEDICAL BILL.—The *London Lancet* of June 14th states that the Government are determined to press the Medical Bill. It has twice passed the House of Lords and is expected to be up for a second reading in the House of Commons in a few weeks. Nothing but the most serious political complications can justify any further delay. The profession is anxious to have the bill become law at an early date and there is every prospect of its being carried through before the adjournment.

A JUST VINDICATION.—Dr. D. McLean, of Detroit, Prof. of Surgery Ann Arbor Medical College, has been elected President of the Michigan State Medical Association. This is a most gratifying triumph for that gentleman, not only as showing the confidence and esteem of his confrères, but also as a vindication of the verdict of the jury in the outrageous libel upon his character made by the *Detroit News* a short time ago. We congratulate the Dr. on the result.

IODINE PREPARATIONS AND QUININE.—Rabuteau, in a communication to the *Société de Biologie*, (*Deut. Med. Zeitung*) calls attention to the occurrence of disagreeable symptoms in the digestive organs and nervous system from the combined administration of iodide of potassium and sulphate of quinine. He insists that twenty-four hours should elapse between the administration of an iodide and the quinine. He also warns against the use of quinine during the menstrual period, as it sometimes gives rise to severe symptoms.

PERSONAL.—We have much pleasure in learning that T. S. Covernton, M.D., son of Prof. C. W. Covernton, M.D., of Trinity Medical School, has obtained the License of the College of Physicians and Surgeons of Edinburgh, after a stringent examination,—a fact which we may readily believe, since the proportion of the "plucked" has reached

50 per cent. of the candidates. This should serve as an adequate refutation of the puerile insinuations against the Scottish Universities, made by certain magniloquents in this Province.

APPOINTMENTS.—Dr. G. A. Bingham has been appointed Assistant Demonstrator of Anatomy in Trinity Medical College, Toronto. Dr. W. Henderson has been appointed Demonstrator of Anatomy in the Kingston Medical College. Dr. W. J. Young has been appointed Assistant Surgeon Huron Battalion of Infantry, *vice* Dr. Gouinlock, resigned. Dr. J. W. McLaughlin has been appointed Assistant Surgeon West Durham Battalion of Infantry, *vice* Dr. Bryson. Dr. Harris has been appointed Medical Health Officer for the City of Brantford.

LACTOPEPTINE.—This well-known remedy is constantly gaining in favour with the profession in the treatment of bowel complaints in children, especially in cholera infantum. Our own experience in its use in the latter affection, leads us to bring it again under the notice of the profession at this season of the year. It may be combined with bismuth, calomel, ipecac, or any other agent that may be indicated. It aids digestion, controls the action of the bowels, modifies the secretions promptly, and produces no disagreeable after effects.

A NEW TRUSS.—We have been shown a new truss recently introduced by Messrs. Toms & Co., of this city. It is what is called a belt truss, which may be adapted to any form of hernia. The pad is fitted with a V shaped spring, which it is claimed secures upward and inward pressure, varied by adjustable springs. Surgeons who have tested the truss in their practice, state that the results have been highly gratifying and satisfactory.

CEREVISIÆ IN OBSTRUCTION OF THE BOWELS.—A correspondent writes to say that a case of obstruction of the bowels lasting twelve days, in a child four years of age, was ultimately relieved by the use of *cerevisiæ fermentum* (beer yeast). Whether this was a case of *post hoc* or *propter hoc* it is of course impossible to say, but the issue was no doubt satisfactory.

CIDER AND STONE IN THE BLADDER.—The Paris correspondent of the *London Lancet* states

that according to Dr. Dumont, stone of the bladder is almost unknown in Normandy. This he attributes to the use of cider in place of wine and beer. Cider, he maintains, is therefore an excellent remedy for gravel; also for obesity and certain forms of gastritis.

ORGANISMS AND DISEASE.—The *British Medical Journal* says that it is very easy to find organisms in any disease if the proper methods of preparation be observed, but is very much more difficult, and far more important, to establish that there is any connection between the organism and the disease.

BRITISH DIPLOMAS.—Dr. H. H. Graham (Trin.) has been admitted to the M.R.C.S. Eng., and Dr. F. H. Sawers (Trin.) to the L.R.C.P. Lond. Dr. D. G. Inksetter (McGill) has obtained the double qualification, L.R.C.P. & S. Edin.

THE PREVENTION OF BED-SORES.—A solution of gutta-percha in chloroform (four to thirty) is useful to protect the skin over projecting bones and to prevent bed-sores in wasting diseases.

TRIPLETS.—Dr. J. Sutherland, of Bedeque, P. E.I., reports a case of triplets. The children weighed 6, 6½ and 7¼ lbs. respectively. Mother and children all doing well.

Books and Pamphlets.

CLINICAL LECTURES ON MENTAL DISEASES. By T. S. Clouston, M.D., Edin., F.R.C.P., E., Physician Superintendent of the Royal Edinburgh Asylum for the Insane, etc. Philadelphia: H. C. Lea's, Son & Co. Toronto: Williamson & Co.

This is decidedly the most practically useful book on mental diseases we have ever yet seen, and we are convinced that every attentive reader of its rich and highly instructive pages will dissent from the first line of the author's preface in which, with that modesty which is the usual accompaniment of genuine merit, he premises that "Another book on Mental Disease almost needs an apology." It is indeed too true that a few, perhaps too many, books devoted to this subject have needed an apology, not only in the preface, but

also at the close. Dr. Clouston's book was much needed, therefore it stands in no need of "an apology." It was needed by the entire body of the medical profession, and to students of medicine it will prove a real treasure. It is not a mere didactic treatise, dealing in puzzling abstractions, and interlarded with profitless speculations. It "holds the mirror up to nature," and shows insanity in its multitudinous and marvellous images, with a fidelity of depiction which cannot fail to command the commendation of every reader who has had large opportunity of observing the mental and physical phenomena of the disease. It may, in truth be styled an assemblage of pen-photographs, every one of which is true to life, without the failure of a single lineament, or the distortion of a single feature; nothing deserving of notice has been omitted in the description of cases, and nothing of surplusage has been daubed over them, and the book has one merit, which indeed we had every reason to expect; it is that of perfect and honourable candour. Dr. Clouston has not been afraid to impart valuable instruction by instancing his own mistakes or failures. This is a virtue much to be commended, for it is far too much desiderated, both in medical teachers and medical writers. A sea-coast studded with wrecks, may be safer to the navigator than a strange and smiling sea with hidden reefs. The young practitioner who loses his first patient receives, perhaps, the best lesson he has ever had, whilst he whose success has been due to the resisting vitality of his patient, which has triumphed over the combined force of the disease and its erroneous treatment, has made a very perilous start. Of the printing of this book, no eulogy could be too high. We wish we could say the like of its illustrated plates. The student must not imagine that they are fair average representations of the morbid anatomy of the brains of the insane. They are no doubt faithful representations of special extraordinary cases, the colouring of which has, perhaps, been rather over-done by an over-zealous artist.

BRAIN EXHAUSTION. By J. Leonard Cornell, M.D. New York: D. Appleton & Co. Toronto: Hart & Co.

This is a short octavo of 28 chapters. It might have been made a more generally useful book had the writer more largely eschewed medical termino-

logy. It contains much matter that might be more useful to the reading public than will be found instructive to medical scientists. The author's strictures on the cram system of education, which is devastating so many brains and bodies in the United States, and not a few in Canada, should be well pondered over by all parents of precocious and ambitious children, and by all teachers who are in danger of falling into the evil habit of top-knot cultivation. The infant philosopher is destined, too often, to shine as the adult fool; and many a boy who has been scoffed at by his fellows and derided or frowned on by his stilt-walking teacher, has come to the front in life's battles, and carried off the laurels which have evaded the grasp of those who far distanced him in early years. Should another edition of Dr. Cornell's book be called for, he will do well to prune it of medical technicalities, and extend its more useful parts, even at the expense of omitting some that may not be unprofitably dispensed with.

DEUTCH'S MEDICAL GERMAN. New York: J. H. Vail & Co. Toronto: Williamson & Co.

This will prove a useful little book, small enough to be carried in a young man's coat pocket. It is "a manual" intended for the use of those physicians who have to practise among Germans, and are not familiar with their language. It gives in German, and, many thanks to the author and his publishers, not in the abominable Gothic type, but in very clear Roman. 1st. Terms relating to the various organs and parts of the human body. 2nd. The names of diseases and their symptoms. 3rd. Conversations such as pass between physicians and their patients, in examination of their condition, and in stating the proper treatment. To those students who desire to visit the medical schools and hospitals of Germany, it seems to us it would be a most useful pocket companion.

PATHOLOGY, DIAGNOSIS AND TREATMENT OF DISEASES OF THE RECTUM AND ANUS, by Chas. B. Kelsey, M.D., New York, with two chromolithographs and nearly one hundred illustrations. New York: William Wood & Co.

We have perused the above work with much pleasure and profit. The work has for its basis the volume on the same subject contributed by the author to Wood's Library of standard medical authors for 1883, but contains many important

changes and additions. Each branch of the subject under discussion has been brought fully up to date, and we regard the work as one of the best of its kind. It embodies all the recent advances in pathology, as well as the best and most improved methods of treatment.

ON THE PATHOLOGY AND TREATMENT OF GONORRHOEA. By J. L. Milton, Senior Surgeon to St. John's Hospital for Diseases of the Skin, London. Fifth edition. New York: William Wood & Co

This is the February number of Wood's "Library of Standard Medical Authors," and contains what the author has written in various periodicals upon the subject. It is a very complete treatise upon this disease, and although all the writer's opinions cannot be endorsed, the book will be read with profit.

PRACTICAL MANUAL OF OBSTETRICS, by Dr. E. Verrier. Fourth edition, with the four "Obstetric Tables" of Prof. Pajot. Revised by Ed. L. Partridge, M.D. New York: William Wood & Co.

DIAGNOSIS AND TREATMENT OF DISEASES OF THE HEART, by Constantin Paul. Translated from the French. New York: William Wood & Co.

These are the March and April numbers of Wood's Library respectively. The former will be found a most excellent resumé of Obstetrics. The authors are men eminent in their specialty, and the work has a well-deserved reputation in France, having already in a very short time reached a fourth edition. As a text-book it occupies a position intermediate to the Students' Manual and the elaborate treatise. The latter is replete with useful information on the subject treated upon, and will be found a useful addition to the physicians' library.

Births, Marriages and Deaths.

On the 25th ult., Dr. W. J. Douglas, of Castleton, to Mattie M., eldest daughter of Robt. Macklam, Esq., of Brighton, Ont.

At Digby, N.S., on the 20th of April, R. Stephen, M.D., aged 76 years.

At Quebec, on the 10th ult., Dr. J. E. Landry, aged 70 years.

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APHASIA.*

BY J. WORKMAN, M.D., TORONTO.

It will be remembered that I last year read a paper on aphasia, which I had hoped would elicit some useful discussion, for the affection is certainly one of much interest, not only to the attentive student of psychology and the pathological anatomist, but indeed to the general practitioner of medicine; nor is its occurrence perhaps so rare as to warrant the conclusion that it may with propriety, or professional advantage, be relegated to the domain of the profitless unknown. There are, in my belief, very few medical practitioners of prolonged observance and discreet attention, who have not, in the course of years, met with cases of speech disorder, which must have led them to desire the attainment of a more intimate acquaintance with the literature of cerebral physiology and pathology, than they had previously regarded as deserving of serious consideration, or, I might perhaps, with more justice say, as adequate compensation for the expenditure of those fragments of time which the exigencies of professional duties leave at their disposal, and which they find less than sufficient for the further study of subjects of every day imperative importance. I confess, however, that when, last year, I found, that after finishing my reading, not a single member present moved a lip, either in corroboration or in disapproval of the contents of my paper, I was quite undecided as to whether I should feel more mortified, or disappointed. If the association was mercifully condoning my intrusion, by the charity of its silence, it was most consistent with sound discretion, to reciprocate the charity. When our friends may be so forbearing and generous as to

abstain from adverting to our failures or foibles, it would be a sorry return for their tender kindness, to attribute their reticence either to lack of discernment or want of social frankness. I did, however, reach the conclusion, that my paper, either from its own demerits, or from the unsuitability of its subject, had failed to interest the audience, to the extent which I had hoped for, and I resolved to consign it to the limbo of the untimely. I therefore declined to accede to the request of a polite medical journalist who wished to present it in his columns, and when another gentleman whose professional ability is exceeded only by his urbanity, expressed his desire to have a reading of it, I had to reply that it was no longer among the findables. Both of these gentlemen assured me that I had judged erroneously of the silent verdict of my confrères, and as I had every reason to confide in their veracity and candour, I felt relieved from the obligation of my unspoken, though strongly purposed vow, never again to trespass on the patience, or the valuable time, of this association, with any matter or paper which I might fear would prove uninteresting or distasteful.

Having premised so much in honest explanation of my past fears and misapprehensions, I shall now, with as much brevity as the nature of my subject will permit, submit to your consideration the following observations:

The term aphasia, or absence of the faculty of speech, is of much wider range of application than may, at first view, by those who have not devoted much time to this branch of medical literature, be supposed. It has been only of recent years that physiologists, pathologists, and clinicians have devoted themselves to its earnest study, in connection with special cerebral conditions. It is true that many years ago Gall ventured to advance certain conceptions as to the relation between human language and particular parts of the brain, but unfortunately for the prestige of his theory, it was associated with a host of overlapping phrenological conjectures which proved repellent to scrupulous sober investigation. But long before the age of Gall the relation between the faculty of language and certain conditions of brain, had been observed, not only by physicians, but also by historians and naturalists. Hippocrates, Thucydides and Pliny have recorded instances of deprivation of speech, consequent on injuries to the brain.

*Read before the Ontario Medical Association, at Hamilton, 4th June, 1884.

Pliny tells us of a man who—"ictus lapide oblitus est literas"—and of another, an orator, named "Messala Corvinus, who, under disease, lost the memory, not only of the names of his servants, but even of his own name." Morgagni, in Italy, 150 years ago, described various cases of aphasia, in his celebrated "*epistles*," with such admirable precision, that one might almost imagine that later investigators had found in them the germs or indeed the outsprung stems of modern discoveries. Unfortunately, however, for the fame of the pioneers in discovery, it has happened in medical science, usually, and in medical literature almost universally, that the race and the rage are ever for the new, and olden treasures, not only are doomed to forgetfulness, but are actually ignored by the panting aspirants for authorial glory. Who, in the present day, ever meets with a student, nay indeed with very many teachers, who hold in high esteem the works of Sydenham, Cheselden, Cullen, Abernethy, Cooper, or even the Hunters or Charles Bell? Bah! these were all merely purblind moles, groping and rooting in the dark. Their optics could not have borne the brilliance of our electric lamps; their snail-pacing thoughts would never have reached parturience under the bare anticipation of our age of steam and lightning speed, of telegraphs and telephones, dynamographs and myographographs, of Listerism, and Pasteurism, and Kochism, of evolution and involution and devolution, and the survival of the fittest, which means the utter extirpation of all memory of the old fogies and their glimmering rushlights. Well, since the fates seem so to have decreed, be it so; peace to the ashes of the departed. They are gone, and to be forgotten is the lot of humanity. Let us not waste our tears over their useless bones, but rather speak of their working successors.

It is now a little over thirty years since Broca, after long and patient clinical observation, announced the fact that aphasia stands in direct connection with lesion or diseased condition of the inferior or third convolution of the frontal lobe of the cerebrum, and by far preferentially with that of the left side. I confess that when I first became acquainted with this teaching, I received it with something, not exactly of contempt, but savouring rather much of that semi-derision with which complacent ignorance is wont to regard unlooked for new announcements, which fail to square with

petrified preconceptions. I had read Gall and Spurzheim, and some other minute brain geographers, until I had fallen into utter skepticism on the entire subject of brain regions and boundaries, and I could only regard the great capital organ as a supreme solidarity, or aggregation, not of independent principalities or states, each possessing functions or legislative powers of its own, but all as acting in consentaneous harmony, and all as, some how or other, sharing in, or sympathising with, the acts of each part. It takes time to draw any of us, but especially those of the foggy class, out of our old deep-cut ruts. Indeed I sometimes almost doubt whether I can ever get completely out of mine; but when, from year to year, and day to day, I learn more and more of the facts brought to light by clinical and autopsical observance, and when I see that the doctrine of Broca now ranks in its adherents almost the entire body of eminent observers of the present day, it seems to me that longer holding out is almost as hopeless, if not as senseless, as striving to stem the tide with a pitchfork. I can see indeed no way of getting back into my old cozy quarters, but that of unreading all I have read on my lingering way out, or, which is just equivalent, and far less impracticable to one of my years, that of forgetting it all; and as our early impressions always survive those of later birth, my case, in this regard at least, may not be quite hopeless.

The aphasia which paramountly, if not exclusively, engaged Broca's attention, was but one form of the affection, but it was that which is by far the most usual. It consisted in the inability to articulate words. It was therefore a failure in the muscles of articulation to obey the behests of the will, the simplest and best designation of which is *motor-aphasia*. With this form, in various degrees of evolution, you, Mr. President, must be, as I myself long was, far too familiar. In that hopeless mental disease, properly best known under the designation of general paresis, motor-aphasia is often an early and a surely progressive symptom. In corroboration of Broca's doctrine I cannot here do better than to quote the following passages from the recently published lectures of Dr. Clouston, of the Royal Insane Asylum at Edinburgh, whose recently published lectures on mental diseases, constitute the most valuable work on the subject I have ever had the pleasure of reading.

Page 272—Lect. 10.—“I have many times seen general paralytics aphasic after congestive attacks. In such cases, and in all cases where the speech was specially affected during the disease, I have always found after death that the third frontal convolution of the left side, and that region of the brain, had the pia mater especially adherent to the cortex.”

Page 277—Lect. 10.—“I had once a patient, a young woman, (G. N.) under thirty, who, having heart disease, became hemiplegic on her right side, and aphasic after the birth of a child. Immediately after these there came on great mental depression, with suicidal tendencies, for which she had to be sent to an asylum. The hemiplegia passed away, but the aphasia remained all her life; and when the mental depression passed off, in a few months she gradually became exalted, and remained so for some months. Then she again became depressed, and was mentally a typical case of alternating insanity (*folie circulaire*) for the seven years she lived after this. She at last died of heart disease, and I found Broca's convolution almost destroyed by an old embolism, but the rest of the brain with only the traces of repeated excitations and congestions.”

Page 279—Lect. 10.—“I need hardly say that if the lesion affects the posterior portion of the third frontal convolution of the left side, or the island of Reil on that side, or the fibres of communication inwards from those parts, or certain portions of the extra-ventricular nucleus of the *corpus striatum* of that side—in such cases we will have the aphasic speech symptoms. It is a disputed question whether complete aphasia can co-exist with perfect integrity of the mental faculties. If the lesion be strictly limited to the speech centre, which it very rarely is, the loss of mental power may be slight, but whether we can have mental completeness, according to the previous standard of perfect health of the individual, is another matter. I do not believe we can have such completeness if we could apply proper tests. I have never seen a case where it existed.”

The name of Dr. Clouston is, in my estimation at least, a guarantee for the safety and soundness of any opinion bearing his approval. He has made insanity and its concurrent bodily ailments the supreme study of his life, and he had the great advantage of serving for several years under the distinguished Dr. Skae, a gentleman who himself

enriched the specialty with some valuable contributions. Dr. Clouston has not jumped in the dark to his conclusions. He studies the morbid anatomy of the insane in the great book of nature, on the *post-mortem* table, and he never misses holding an autopsy unless when the friends of the deceased patients refuse him the privilege. I cannot close this allusion to his work without recommending it in the highest terms to every member of the medical profession, for it will certainly be read with both profit and pleasure by every thoughtful practitioner or student.

You will have observed that Dr. C. expresses his doubts as to the existence of well-marked aphasia in the presence of conserved mental power. It is certain that as regards the class of patients with whose mental condition he was most intimately acquainted, that is to say, persons of unquestioned insanity of mind—Dr. C's statement must be correct. But all aphasics are not sent into lunatic asylums, and it has been discovered in some countries, in which medical examination may not have been so exact as it is in Scotland, that aphasic persons have been deemed to be insane who were found not to be so.

There is a very interesting, and indeed a very puzzling form of aphasia, to which Kussmaul has given the name of *verbal deafness*—or deafness to words—a rather misleading designation, inasmuch as no deafness is present. The patients hear quite well, but the words spoken to them fail to convey their proper meaning, or indeed any meaning whatever, unless they are conjoined with gestures which of themselves may indicate the meaning of the speaker or interrogator; and then, to prove that the patients are not unable to understand what is thus communicated, they perform the acts required of them—such as putting out the tongue, and so forth.

Dr. Seppilli, of Imola, and Dr. Brugia, of Ferrara, Italy, have given in the last issue of the *Rivista Sperimentale*, and of the *Archivio Italiano*, respectively, two long and very instructive articles on this form of aphasia, from which I might advantageously quote largely; were it not that it would be unjust to these writers to make abstracts which would be imperfectly appreciated when detached from the contexts—I must therefore in fairness to them, and in compassion towards you, limit my citations to a few summarized facts.

Dr. Seppilli has exhibited, in copious tabular forms, the details of twenty cases gathered by him from the medical histories of twenty persons who came under the observance of various physicians, nineteen of which have been continental and one English. It might almost go without saying that the majority of these have been German—no less than thirteen of the whole number. This fact may serve as a sufficient assurance of the minuteness, if not also of the accuracy of the records. In the separate vertical columns Dr. S. has given the ages and sex of the patients, the aphasic symptoms, the degree of intelligence, the state of sensibility and motility, and last, the autopsic findings. In seven of the patients the state of intellect was more or less weakened; in the remaining thirteen it was not affected. The hearing was perfect in 18; in the remaining two its condition is not stated. Dr. Seppilli has given the pathological state of the brain in 15 of the 20 cases, in which *post-mortems* were obtained, and he has added to these two cases of his own, of which he has given very ample details, thus making 17 well-observed cases. The autopsic results are thus summarized by Dr. Seppilli:

In all the 17 cases the first temporal convolution on the left side was found diseased.

In one of the 17 the second temporal convolution was diseased, and in two others in company with that of the right side. The third temporal convolution was diseased in only one of the two above named, and then on both sides. The island of Reil was diseased on the left side in 5; third left frontal in 4; the second left frontal in 2; the first left frontal in 2; the ascending left frontal in 3; the inferior parietal lobule on the left in 5, and on the right in 1; the angular gyri in two on the left and one on the right; the occipital convolutions in two on the left, and on both sides in one of these. *The right temporal lobe was not found isolately diseased in a single case.*

It is to be noted that the third left frontal, or Broca's convolution, was found diseased in only four cases, and the island of Reil, which later writers have associated with the foot of the third frontal, as the governing centre of speech articulation, was diseased in five cases on the left.

This preponderance of diseased condition on the left side of the brain seems, in this form of aphasia, to show an interesting parallelism with

the diseased condition found on the same side in motor aphasia, but at the same time a very notable difference as to convolutional localization. It is seen that while motor aphasia has its morbid seat in the third frontal convolution and the island of Reil, the aphasia called verbal deafness has its seat preferentially, in the first or uppermost temporal convolution on the left, and the diseased condition of the second temporal does not occur isolately, but always by extension from the first, and then only limitedly, in contiguity with the first. The part diseased is invariably the convolutional cortex, with occasional dipping into the white medullary matter beneath it. The meninges are found tenaciously adherent to the cortex, from which they do not separate without dragging off some of its softened and disintegrated constituents.

When Broca condensed his cerebro-lingual creed into the quaint expression, "brain left-handedness," many cynical critics were tempted to regard *his* brain as entitled to the first rank in the class of strabysmal thinkers, but many who then scoffed have since learned to admire the aptitude of his laconic expression. The discoveries of Sir Charles Bell taught us that the voluntary muscles of the right side are under the government of the left side of the brain, and *vice versa* those of the left side under the government of the right side of the brain. Bell did not venture to assign the motorial sovereignty to any special parts of the brain, but modern physiological experimenters have amply filled up the lacuna. Hundreds of zealous cerebral explorers, whose findings are often opportunely confirmed by able clinicians, have placed the doctrine of cerebral localizations on a basis from which the cavils of fault-finders and flaw-hunters have failed to upset it. If our right hands are pre-eminently, though not indeed exclusively, under the control of the left side of the brain, why should not that other, too often unruly, member, the tongue, and its motor-coadjuvants, be placed under the same dignified authority? But it will be objected that the tongue and its associate speech muscles, are not one sided movers, yet they sometimes are one sided non-movers. It does not however follow because the left side of the brain, or in this relation, to speak more pertinently, Broca's convolution, with, probably, the island of Reil, is the chief seat of speech legislation, and, it may be, of idea-motor inception, that the right

side of the brain should not be a willing co-operator. A good wife governs best when she best aids her husband, but when she refuses to him the prerogative of inceptive action and predominant direction, the peace and prosperity of that house are certainly seriously jeopardized; and have we not all seen how great is the embarrassment in business affairs, of even the cleverest woman, when death has taken away her best counsellor and guide? It is just so with our speech organs when their ruling cerebral centres have been dethroned by disease; and, alas! it is too often, if indeed not always, found, that when the left motor-speech centres have become diseased, their homologues on the right side fail to assume the function of speech direction.

It has, I think, been clearly established, that motor-aphasia has been, in the great majority of cases, associated with some lesion or disease of the left cerebral centres. It is also a well-known fact that the great majority of mankind are right-handed. There surely must, in these coincidences, be something other than mere accident. But if right-handedness be, through the intermedience of left brainedness, the normal associate of speech articulation, and if both stand in directive relation with the same side of the brain, so that paralysis of the one is usually associated with the same morbid condition in the other, what should we expect to be the autopsic cerebral findings in the cases of left-handed aphasics? Hitherto but few opportunities for learning the facts in this class of cases have been presented. Westphal has, however, recently detailed a case bearing directly on this question. "It was that of a man of 45 years, who from the year 1879 had been subject to convulsive attacks in his right members, accompanied by loss of consciousness. At a later period paresis of these parts presented, with bilateral papillary stasis and complete blindness. There was no disturbance of his speech nor any sign of motor aphasia, or of verbal deafness. This person was, from his childhood, left-handed. He died on the 9th of November, 1883, and at the autopsy there was found a large tumour in the left temporal lobe which was by it completely destroyed." This case is in perfect analogy with the fact of absence of motor aphasia in those left-handed persons in whom the convolution of Broca (the foot of the third frontal) was found destroyed. Westphal's patient,

as we have seen, was left-handed, and the lesion of the left temporal lobe ran its course without any symptom of *verbal deafness*.

It is here to be observed that Dr. Seppilli was treating, not of *motor aphasia*, but of that other form which Kussmaul has called verbal deafness or sensorial aphasia; this latter form, Seppilli labours to prove, has its cerebral location paramountly in the first temporal convolution on the left side. The case is of little value as regards the absence of motor aphasia, for we are not informed of any morbid condition of the frontal lobe in Broca's convolution, or in the island of Reil; but if it be the fact that sensorial aphasia, or deafness to words, stands related to the left temporal lobe, then in Westphal's left-handed man the lesion was on the wrong side for production of this speech affection. The brains of left-handed men would therefore seem to be properly called right-handed.

In amnesic aphasia, or that form which consists in the loss of memory of words, and which may or may not be associated with loss of articulating power, a very interesting fact is the progression of the affection as regards the order or sequence in which the parts of speech cease to be remembered. It is usually found that nouns are the first to be forgotten, and next to these verbs. I think the very same fact obtains in aged persons, and here I have the unpleasant advantage of speaking from personal experience. Kussmaul expresses the belief that this progression of failure of recollecting power probably depends on the greater or less degree of intimacy in which the conceptions are connected with their corresponding verbal signs, and as the idea of a person, a thing or an action is conjoined with its designating vocable less intimately than are the abstractions of quality, resemblance, properties, etc., it is clear that when the memory begins to fail, those symbols which are most feebly bound to thought will be the most readily obliterated. It is easy to discover that the mere name contributes but in a very slight degree to enable us to acquire the concepts of personalities or objects; we might almost say that it is an accessory element joined to a sensitive image, which image has within itself whatever suffices for constituting a distinct objectivity; abstract ideas, on the contrary, exist only in so far as they are to us symbolic expressions

which give to names their essential character and their stable aspect." If Kussmaul is right here, how senseless must be almost the entire prevailing system of present day cram education, which at the expense of unspeakable torture to the child and endless agony to the teacher, stuffs the poor little victim's brain with mere words, which have no adhesive property that may ensure their remembrance. "Further," says Kussmaul, "when we consider the constituents of language, we cannot fail to observe the enormous numerical disproportion that exists between substantives and verbs on the one side, and the whole of the grammatical elements on the other. It seems quite reasonable that the weakened memory should more readily evoke the recollection of those vocables of which the number is fewer and the use less variable (as articles, pronouns, prepositions, etc.), than that it should not among the multitude, hit upon the symbol appropriate to the designation of a given object or a determinate action."

We are all well aware of the fact that certain persons are possessed of special forms of memory, one for names of places or persons, another for dates, a third for poetical compositions, etc., etc., and these peculiar, or as we might say, automatic faculties, seem by no means to be necessarily conjoined with superior intellectual strength, for we meet with them sometimes in imbeciles, or even the semi-idiotic. Bastian, in explanation of this phenomenon of memory has recourse to the supposition of the possibility of a distinct anatomical seat for the sensitive elaboration of words used for designating persons, places and things. "It is," he says, "rational to suppose that these terms may be in more immediate relation with the *perceptive centres*; whilst the words for the other parts of language would be more intimately associated with the regions in which the *perceptive processes* are mixed up in the more complex and more intellectual operations. Hence, in general, the inaptitude to recall nouns and the errors fallen into in names of persons, places and things, would be troubles accompanying lesions or alterations in the *perceptive centres*; whilst, on the other hand, the extreme forms of amnesia must, most probably, be associated with marked trouble in the *intellective faculties*."

This explanation of Bastian is, of course, no more than a gratuitous hypothesis, but it is not devoid of fascinating plausibility.

A very interesting, though not always, as you, Mr. President, must not seldom have realized, a very pleasant fact, connected with aphasic patients, is that of their sudden and quite unexpected interjectional outbursts, long after their linguistic powers in other directions have seemed to be totally extinct. Falret has very truthfully noted the fact, that "an aphasic, under the influence of fright, anger, rage or any other strong emotion, will let fly an energetic expression, an interjection, an oath, which he articulates with great exactitude, and even a whole string of them in succession; but a little afterwards, when calm returns, it becomes impossible to him to articulate again the words which had sprung up, as if instinctively," in his devastated field of ideation. Might we not charitably infer that something analogous to this desert cerebral condition, exists in the brains of persons addicted to the senseless habit of profane swearing, who fill up with interjectional expletives, those linguistic vacancies which their intellectual poverty renders them incapable of otherwise fitly tenancing? Imperatively and utterly to suppress the profane objurgations of these persons would be nothing short of reducing them to amnesic aphasics. Pass through the odoriferous knots of the great and the little unwashed, who ornament our street corners on Sunday evenings, or hearken, reluctantly, to the silly twaddle of a string of our dandy promenaders, and then tell us how these poor creatures could contrive to escape profound mutism if deprived of their connecting linguistic links. As well might you expect that a bungling mason, without mortar or shaping-tools, could build a sound and sightly wall out of incongruous boulder-stones! Men of good sense and cultivated minds do not swear, because they have no room for oaths in their discourse. Be considerate, then, towards the poverty stricken bipeds. Deal with them as you have to deal with your young victims of chlorosis, who will eat mortar, tobacco, pipes and other nasty things, until you improve their blood and rectify their nervous aberrations. But here I should apologize, for I have fallen into an impertinent digression. Happily the age has passed away in which profanity of language was regarded as the stamp of gentlemanhood, and the members of our profession find that it does not in the least detract from their prestige to appear aphasic in the art of swearing.

Before closing this rather discursive paper I may properly allude to another form of speech deprivation, which Kussmaul calls *verbal blindness*, or the inability in persons who have previously been able to read printed or written words, to comprehend their meaning. This morbid condition may be, and probably most frequently is, associated with verbal deafness, and when it is so connected it is reasonable to believe that the underlying cerebral morbid condition is more extensive and formidable. Both verbal blindness and verbal deafness stand in close affinity with amnesic aphasia, but sometimes the latter may be supposed to be present when it is not. Dr. Seppilli discovered that one of his patients who was so deaf to words as to appear to hasty observers completely dumb, had neither forgotten the meaning of words nor how to articulate them. Her expressions were, of course, purely spontaneous, for she had no dialogistic capability. To nothing spoken to her could she make appropriate response; but the little she did speak was normally pronounced, e.g., "Please, Doctor, send me home; I do not want to stay here; I am quite well; my name is Assunta." Dr. S. was unable to test her reading or writing capacity, as she was "analphabetic." In this case there was neither motor nor amnesic aphasia. But this exemption was not to be interminable. In a few months she had an apoplecticiform attack, from which she fell into a state of transient semi-coma, and lost the power of speech. She survived this attack about two months, and died finally from pyemia, consequent on a rebellious parotitis, and intractable bed sores over the sacrum and the trochanters. The post mortem showed the whole surface of the first temporal convolution on the left side, and the adjacent border of the second, diseased, besides several spots on the first and second frontal convolutions, and the orbital region of the third frontal, but not its middle part, or its foot. This exemption from diseased condition in Broca's lingual region, taken in connexion with the absence of previous motor-aphasia, is deserving of consideration, whilst the diseased position of the temporal lobe, taken in association with the patient's verbal deafness, seems to indicate for verbal deafness a cerebral location distinct from that of motor-aphasia.

It is not only natural, but really necessary, that functional disorders which can exist separately

from, and independently of, each other, should have different and distinct cerebral local centres; but considering the intimate relationship that, in the normal state, exists between the faculties of hearing and seeing, on the one side, and vocal and written language on the other, it must also be necessary that structural media of inter-communication between the several centres should be provided. (*Vide Archives*, March, 1884, page 121, for Kussmaul's, and page 135, for Wernick's ideas of the arrangements.) It is easy enough, on paper, to diagram anatomical arrangements to meet the exigencies of physiological hypotheses, yet such delineations are often conducive to the introduction and the retention of injurious errors. Kussmaul's diagram of four small circles, surmounted by his large *ideogenetic centre* container, with their graceful curvilinear connectors, is rather fascinating; but until anatomy shall have shown that it is a veritable representation of cerebral arrangements, and not a mere vision of his mind's eye, it might be as well that we do not let it any deeper than this poetic organ into our domain of mentality. In Wernick's brain map (p. 135) we see how easily and gracefully his little curve, connecting the regions x and y passes across the rubicon of the Sylvian fissure, but when we try the experiment on a real human brain, we must certainly discover that the path is not so short nor so easy to trace as the map shows it. The most, or the best we can say of these anticipative delineations of yet unexplored cerebral mail routes, is that they are better suited to please the imagination than to convey reliable or useful instruction or sound knowledge.

I am well aware, gentlemen, that to those of your number who have had the good fortune and the patience to read the elaborate article by Kussmaul on Aphasia, in Ziemssen's Encyclopædia of Medicine, this paper must appear a very lame production; but its object has not been to treat exhaustively of the numerous varieties of morbid speech defect. My chief desire and aim have been to invite from my auditors such interesting facts in this relation, as have fallen under their own observance, for I cannot doubt that some of you must have encountered cases of cerebral disorder in which aphasia, in some form or other, or in some degree, has commanded your thoughtful attention, and no little increment to our knowledge of a functional disorder, whose study has been of so recent inception, can fail to prove instructive.

LATER ANTISEPTICS IN PRIVATE SURGICAL PRACTICE.*

BY N. A. POWELL, M.D., EDGAR, ONT.

In discussing the treatment of wounds, a subject confessedly the most important in the whole domain of surgery, we have no longer to ask, "Shall antiseptics be used?" That question has been answered, and in its place have arisen the queries "What antiseptics shall we use?" and "How shall we use them so as to obtain for our patients the greatest safety and benefit, and for ourselves the least trouble and expense?" The principles which underlie their scientific use, and with which for all future time the honored name of Sir Joseph Lister will be associated, briefly stated, are:—1st. That in the air, in fluids, and in the dust around us there exist particulate living bodies which may gain access to any wounds not subcutaneous. 2nd. That entering a wound they are the active agents in setting up putrefactive fermentation in its discharges. 3rd. That if they are absolutely excluded or are rendered innocuous, fermentative changes, with their frequently disastrous consequences, will not ensue. These principles the surgical world has, either in words, or in actions that speak louder than words, accepted as proven. Founded upon them we had till recently only that system worked out by the father of all antiseptic surgery, and known by the name of Listerism. It aims to prevent the entrance of germs into wounds, and to keep these wounds strictly aseptic. Volkman modified this by washing the germs from the wound while it was exposed, and then protecting it from them by a dressing similar to Lister's. Billroth disregards the entrance of germs into wounds, or their presence in discharges, but depends on destroying their power for evil by the presence of an antiseptic powder. While carbolic acid remained the only or the chief antiseptic, no modification of Listerism was advanced suited to the requirements of private practice. The original method of Lister, befogged with spray and enshrouded in the folds of a mysterious gauze, the proportion of antiseptic, in which might be anywhere from 5% to $\frac{1}{2}$ of 1%, poisoning the patient or keeping his wound sodden and in an unfavorable state for rapid healing,

irritating the wound till its discharges soaked through the thickest dressings, intricate, troublesome and expensive, had but one thing to commend it to the general practitioner. That one thing was the success attending its full and careful use. My practical experience with it began in 1873, in the treatment of a compound fracture. Ever since then I have followed, sometimes perhaps afar off, the practice of the Lister school. By doing so I have reached some results that by ordinary methods, I could not have hoped for. Of these I shall mention here only one series: Five penetrating wounds of the knee-joint, chiefly axe-cuts, recovering perfectly and promptly. It is but just to say that ice supplemented the action of the antiseptics in each of these cases. In the treatment of less grave wounds, I have like others been seeking constantly for simpler, safer and less costly methods. The spray I long since abandoned for the douche, and the unstable carbolized gauze for that prepared at the time of use with Von Brun's solution. But it is only since the later antiseptics appeared and their value was demonstrated, that I have felt the slightest danger of becoming a contented routinist.

Named in the order of their importance these are: The bichloride of mercury, iodoform, boracic and salicylic acids. Within the last four years they have been employed by numberless careful observers, and conclusions as to their safety and relative value have been reached. The most exact and extensive of these observations have been made in Germany. Based upon the methods of their use in that country, as described in recent literature, or as followed or modified in the New York, Roosevelt, Mount Sinai, and German hospitals of New York city, where I have lately had opportunity of studying them, I wish to describe a method of wound treatment particularly adapted to the needs of private surgical practice. At the same time I do not wish to go on record as advising that any one method of treatment be used for all classes of wounds. The shoemaker who works on a single last is not the one who fits his customers most exactly.

The aseptic condition, close approximation, drainage, the elastic pressure of dry and absorbent dressings, rest and protection, *these* are what we should aim to secure, and through them by the method now to be described, we may expect most

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wounds to heal without suppuration and under a *single* dressing. Under an essentially similar method, Esmarch and Neuber of Kiel, found it necessary to change the dressings more than once in but 11 out of 212 cases of extensive wounds. Made, closed and protected in this way, one may leave, as I frequently have left, wounds to await a convenient hour for further attention at any time within 10 days. Pain, fever, or the appearance of discharges are to be reported by the friends of the patient at once, and are the indications for the renewal of the dressings.

It will be convenient to suppose that a tumor of moderate size, situated on the fore-arm, is to be removed at a country farm-house. The arm of the etherized patient is brought through an opening in a rubber sheet, and the upper part of this opening is drawn closely and secured by a safety-pin, or is laced or contracted by a purse-string of elastic tubing. The folds of the sheet are then so disposed as to convey fluids into anything convenient, placed on the floor to receive them. Next comes the thorough cleansing and disinfecting of the part to be operated on, and of the hands of the operator and his assistant. Soap, hot water, and a nail brush first, and then a solution of the bichloride of mercury, 1:1000 should be freely used.

At the New York Hospital, in the service of Dr. Weir (to whom personally and to whose writings I am much indebted), the field of operation is also bathed with turpentine and alcohol, 1 to 7. The standard antiseptic solution may be prepared easily and with sufficient exactness when and where wanted by dissolving an 8 grain sublimate powder in each pint of water. I am in the habit of carrying these powders in a hard rubber pocket match safe. The recent discovery by Sir Joseph Lister that sublimate is soluble in $1\frac{1}{2}$ times its weight of glycerine, may furnish a still more convenient mode of preparing our solutions. Such a glycerole would doubtless diffuse in water more rapidly and uniformly than a powder could dissolve. The 1:1000 solution is to be mixed with an equal measure of hot water, for use in cleansing sponges and douching the wound. A tank, a fountain-syringe, or Esmarch's inverted and bottomless bottle, arranged as I show you, may be used, but most convenient and portable of all is the syphon douche now presented. This consists of a sinker weighing 3 oz.,

attached to one end of a tube of thick rubber 4 or 5 feet long, on which has been slipped a clip to close the tube when desired. These replace the short afferent tube and light sinker of any good syringe made after the Davidson pattern. Any pitcher will do for a reservoir, and the thick tube coming over its edge will form a curve instead of an angle, which would occlude it partly or completely. A fine nose tip of hard rubber is convenient during operation, but a tapered tube must replace it to inject the drainage tube and the deeper parts of the wound. Constant irrigation, though not required, is harmless. Since the mercuric salt acts injuriously on instruments, rusting and dulling them, and loosing its strength in doing so, we have yet to use for their disinfecting a saturated 1:20 aqueous solution of carbolic acid. In this strength carbolic acid benumbs the fingers dipped frequently into it; hence it is well, when one is his own assistant, to place a towel wet with bichloride solution, when the instruments in use can be for the moment laid down, instead of being returned to and fished out from the carbolic lotion as wanted. The cutting instruments can be conveniently at hand on a plate or platter, while a bowl makes a bath for the forceps. Of these last, since the securing of every bleeding point is so important when the effort is to gain entire primary union, I make mention of the exceptional value of Sir Spencer Wells and Pean's pressure forceps, and of the torsion forceps of Fricke. Good models of these are shown, since bad ones are common. The plan of going down for a bleeding vessel, and lifting into view successively deeper and deeper portions of tissue with a pair of dissecting forceps held in each hand, is worth referring to in this connection. Sponges should be kept and carried in a sublimate solution. Dr. Weir showed me a rubber ice-cap, with large hard-rubber screw top, which made a very convenient receptacle for them. Not less than three basins of warm 1:2000 solution should be provided for the cleansing of the sponges. Passing through these in rotation, they reach the operator clean and dry. This point I should hardly have mentioned if I had not seen sponges so often thrown into and taken from the same basin during an entire operation. Many surgeons, who would not think of using dirty water for their own faces, apply it without stint to their patient's wounds.

The tumor removed, every bleeding point is to be secured by torsion or the catgut ligature so as to leave a dry wound. At present in New York, catgut which after preparation, has been kept in oil of juniper or in absolute alcohol, is used almost entirely. It ties and keeps its knot better than that preserved in carbolized oil. In ligating arteries, I use now only the two larger sizes, as the smaller ones are not strong enough to stand being tied, as Robert Liston said ligatures always should be, "devilish tight." For sutures, however, and in particular for the "sunken sutures" of the Germans—those by which we close together muscle to muscle in the deeper parts, tying the knot far below the skin and obliterating the wound, they are excellent.

The lines of drainage should be next arranged, and in them placed one or more absorbable tubes. I show you those of Neuber, imported from Germany, and those of MacEwan, made by my assistant, from the femora and tibiae of chickens. Since the one form has with me succeeded as well as the other, and since the natural tubes can be bought in the flesh for about the same price as the drilled and turned ox-bone in oil, my decalcified tubes in future will, I think, be after-dinner considerations. If the wound is to be dressed again within a week, either rubber tubes, horse-hair, or Chiene's chromic-acid catgut may be used. The two last I have not found to drain pus well, though they are excellent for the early serous discharges. For closing the wound, catgut should be preferred. Horse-hair answers for adjusting the edges of the skin, and silver wire secured by lead buttons may be needed to sustain tension. If silk be used at all, it should have been prepared by boiling for an hour in a 5% carbolic lotion, and should have been kept in one of the same strength. The line of union is to be dusted with iodoform, and then covered with several handkerchiefs of 10% iodoform gauze, or $\frac{1}{4}$ of 1% sublimate gauze, over which a roller of the latter material is to be applied. The dressing is completed by the adjustment of bags or pads filled with some one of the absorbents presently to be spoken of, by a second roller, and a splint to secure perfect rest to the part. Cheese cloth, boiled in a soda solution to remove fatty matters, and then washed in water to get rid of the alkali, answers for the preparation of the handkerchiefs, the bandages, and the pad covers. Iodoform

gauze is made with this very simply, by Billroth's plan of rubbing the crystals into the meshes of the cloth. From 10 to 20 % will be retained. Another method is to saturate the cheese cloth in iodoform 50 parts, ether 250 parts, alcohol 750 parts, and allow the fluids to evaporate. This gives a 10% gauze. Iodoform is always a desiccating dressing, hence it is important to bring the ends of the drainage tubes through the layers in contact with the wound. Neglect of this in one case where I had drained a compound fracture extending into the elbow joint, caused the end of the drain to be sealed in the antiseptic scab, the serous discharge to be retained, and the temperature to rise to 103° F. All went well again when the mistake was corrected. The great value of iodoform lies in its permanence. It constantly evolves an antiseptic influence, as penetrating and as persistent as its own odor. Being non-irritant, a moderate quantity between the lips of a cut will not prevent union by the first intention. Neuber warns us that not more than 45 grains should be applied at any one time to a raw surface. When first introduced, large wounds, as after hip excisions, were filled with it, and deaths followed. Now we have the authority of Lister, Macormac, Longman, Billroth, Sands, and many others, for considering it to be the best-known antiseptic for direct application to wounded surfaces.

The bichloride gauze is made by simply saturating the cheese cloth with bichloride of mercury, 20 parts, water 4,480 parts, glycerine 500 parts, and allowing it to dry as far as the glycerine will admit. Its active agent, besides being the most powerful antiseptic of which we have any knowledge, is always at hand, is safe, permanent, pleasant to handle, and is only irritating to the extent of producing an occasional slight dermatitis.

We come now, and finally, to the absorbents which may be used to soak up and keep harmless all fluids which our internal drainage has brought to the surface. Of these I show you hygroscopic cotton and the same containing 15% of boracic acid. They will each take up, as I have found by experiment, 16 times their own weight of water, wood-wool, 14 times; german peat, 12 times, and jute, 8 times. Dr. Weir is now testing the ordinary moss of our woods as an absorbent. After drying it in an oven to kill the insects it may contain, he finds it soft, elastic, and able to soak up about four

times its weight of water. The *New York Medical Record* of last week contains a letter from Dr. Lydstone, of Chicago, advocating the use of punk or spunk, a substance used by dentists to dry out cavities in teeth. I show you a piece, part of which when tested was found to absorb 11 times its weight of water. I have not been able to obtain wood-wool from the paper makers here. That shown and also the peat came from Germany. Both are exceedingly cheap, costing only six or eight cents per pound in original packages. Specimens of each are shown as they come to us, others impregnated with equal parts of corrosive sublimate and glycerine in 200 parts of water, and still others, sewed in bags of sublimate gauze ready for use. The wood-wool is made from pine of non-resinous character, is soft, cottony in texture, elastic, and clean to work with. I prefer it to any thing excepting the cottons, which cost many times as much, or peat which costs about the same. Wood-wool collapses when thrown into or saturated with water. On this account the roller first applied should not cover any dressings containing it or the pressure may not be maintained and the result may be compromised. It has, as was recently pointed out by Lister, in the discussion at Woolwich on antiseptic field surgery, the same composition as cotton rags, which may replace it if used in sufficient mass. Dr. F. Lange, who is perhaps the best exponent of German antiseptic surgery in this country, is partial to borated cotton arranged in thick sheets and covered with sublimate gauze. I show you a "compound borated dressing" prepared as he directs.

The story of the introduction of turf, mould or peat may be new to some here present. About four years ago a man applied to Dr. Neuber, assistant to Esmarch in Kiel, relating that ten days before he had while working on the moor sustained a severe injury to the fore-arm. To this had been at once applied a thick coating of mould and a rude splint. On examination the wound was found free from suppuration and either united or granulating well, though there had been compound fracture of both radius and ulna, rupture of the wrist joint and extensive laceration of the soft parts. Neuber followed up this broad hint as to the value of peat, and its use has been attended by rapid and satisfactory healing of the parts it protected. A special advantage of peat is its power

to absorb the gaseous products of decomposition, such as ammonia. Used as a litter for horses the same beds have, according to Dr. Ernest Hart, been in use for two or three months. It absorbs best when slightly dampened, is soft, as you see, and very elastic.

In conclusion, I do not propose to enter into any recital of cases or statement of results. The method advised is one of the antiseptic methods, and results obtained by it belong to that system, the beneficent influence of which can be as little questioned as can be the good to mankind that followed the discovery of the hæmostatic use of the ligature, or the anæsthetic use of sulphuric ether. The materials required can all be carried in a small satchel, and all be purchased with what would be only a fair fee for their first use.

MANAGEMENT OF THE THIRD STAGE OF LABOUR.*

BY GEORGE A. TYE, M.D., CHATHAM, ONT.

GENTLEMEN:—The management of the third stage of labour is always full of interest because it is so closely connected with *post-partum* hæmorrhage. The object of this paper is chiefly to discuss Credé's method, a method lately warmly advocated by some prominent obstetricians. Unless properly limited it may bring disappointment to the practitioner and disaster to the patient. The third stage, like the preceding ones, is a strictly physiological process and requires no assistance as long as the conditions are normal. When, however, the conditions are pathological, then alone is interference justifiable. When the uterus has been for a length of time vigorously engaged in the previous stages it is naturally more or less exhausted, and before commencing the third stage requires a period of rest. After this rest contractions occur spontaneously, at first gentle, then gradually increasing in power; each contraction separates a portion of the placenta, and simultaneously closes the sinuses, and finally expels the whole contents of the uterus. The efforts thus begun continue till all danger of hæmorrhage is past.

This is Nature's method and can never be improved by Art. During this process the accoucheur is only a watchman, keeping the hand over the uterus, to warn him should internal hæmorrhage

*Read before the Ontario Medical Association, June '84.

occur, and convey to him the nature of the uterine action. It is the practice of some to interfere : 1st, by traction on the funis ; 2nd, by external pressure from all sides towards the os. The latter process, known as Credé's method, has been taught and practiced for the last twenty-five years or longer. These methods are both unnecessary, because the process can be accomplished without their aid ; they are both wrong, because they tend to deliver the placenta prematurely, that is before sufficient contraction has set in, and therefore favour *post-partum* hæmorrhage. The method of traction on the cord being rarely practiced requires no comment. Credé's method is taught, considerably practiced, and lately warmly advocated, and that in all cases. When Credé's plan is practiced the placenta may be separated by the combined forces of the uterine effort and external pressure. But it is frequently detached by the external pressure alone, after separating a portion of the membranes which are liable to be retained. The placenta acts as a tampon, and as a stimulus while in the uterus and is of service until Nature's *tourniquet*, uterine contraction is ready. When the conditions are abnormal, such as strong adhesions, and strong uterine efforts fail to deliver in a reasonable time, then the method of Credé is valuable and will hasten expulsion. These cases are rare. It is the practice of this method in *every* case that is unjustifiable and dangerous. For ten years I practiced this method and had a large number of hæmorrhages. I was struck by the fact that in all the labours to which I was called and arrived late flooding had rarely occurred. Cases attended by midwives, who did not interfere, were nearly exempt. These facts caused me to abandon the method and to rely upon the natural process as already indicated; the result has been most satisfactory and convincing during the last seven years.

Dr. Garrigues, of New York, in a recent paper before the Academy of Medicine, strongly advocates Credé's method. His first statement is that it should be used in *all* cases. Amongst the advantages that he claims for it is the *prevention* of hæmorrhage, but proof of this assertion is not in the paper. In the discussion that followed, Mundé speaks of Credé's method as a very excellent one, and free from danger when carried out aright, but qualifies it thus :—"When carried too far it might cause too rapid expulsion and favour inertia." He

still further modifies it by saying, "The placenta should not be expressed until it is detached, but the uterus should be made to contract by manipulation and separate it, then it could be expressed." This statement is true and sound practice, but it is not Credé's method. When the placenta is once detached it is a foreign body and may be safely expressed, even traction on the cord may be admissible.

Dr. Isaac C. Taylor said that he looked upon everything connected with childbirth as a physiological process, and thought we should not interfere with this process. Nature's method was to wait twenty minutes or even an hour. She was fatigued and needed rest. We should not compel her at once to renew her efforts to deliver the placenta. Medical opinion abroad is not now so favourable as formerly. Hofmeyer in a report on Obstetrics and Gynæcology in Germany, says :—"It is unquestionable that a certain reaction has set in against the method of the immediate expression of the placenta after labour introduced by Credé twenty or thirty years ago. As long as twelve or eighteen months ago various voices have been raised, Runge, Dohrn, Schultze, and others, calling attention to the disadvantages of an over hasty expression of the placenta, so that Credé himself has been inclined to again carefully limit the procedure introduced by him. Quite recently the manifold dangers of this method have been very minutely exposed by Attfield, chiefly the liability to secondary hæmorrhage and the retention of membranes. At the meeting of German Physicians at Freyburgh, I had the opportunity of hearing Hegar and Freund prefer an almost absolute expectancy to Credé's method."

When uterine inertia exists not due to fatigue, ergot is our most reliable stimulant, in addition to external manipulation. Sometimes the contractions produced by its use are irregular—a portion being contracted, another quite lax, so that the placenta becomes partially or completely encysted, and is not liberated until the influence of the ergot has passed away, or the hand has been introduced to remove it. As a rule it is best to abstain from its use until the uterus is emptied, then a full dose may be administered to keep up contraction, the hand in the meantime being retained until its effects are manifest, the patient can then be left in safety, and much done to prevent puerperal fever.

REPORT OF A CASE OF EXOPHTHALMIC GOITRE.*

BY J. CAMPBELL, M.D., C.M., L.R.C.P., EDIN., SEAFORTH, ONT.

Mrs. B., æt. 45, a native of England, and mother of eight children, came to me with well-marked symptoms of Graves' Disease, especially as far as the eyes, heart and thyroid gland were concerned. She also complained of menstrual derangement, and was somewhat anæmic. She gave me the following history:—Some time previously one of her children got scalded, and she was very much frightened. Shortly after this the characteristic symptoms of Graves' Disease began to show themselves. She was an occasional visitor to my office at intervals varying from a week to a fortnight, and was treated with citrate of iron and quinine, and tincture of digitalis, and laterally with ergot—the latter drug being sometimes given on account of the menstrual flow being very profuse. During this time she took a trip to see her friends, and while away, all the symptoms became very much aggravated, and in addition, pronounced gastric symptoms developed themselves, and it is to these and the treatment of the disease in this particular case, that we wish to direct your attention.

In January, 1883, the gastric disturbance became marked and troublesome, the patient vomiting her food, medicine and everything she took. The result was, that before March she was reduced to a state of extreme emaciation—was in fact a mere skeleton, and her death was expected daily. At this time the only thing which would remain on her stomach was a spoonful of milk and lime-water. The tongue was red, denuded of epithelium, irritable and tremulous. The temperature at this time ranged from 100° to 101°F. This we attributed to the gastric irritation, or to what was probably gastric catarrh—though elevation of temperature is not an uncommon symptom of Graves' Disease. The pulse was weak, rapid and intermittent, ranging from 130 to 140. All kinds of food however mild, were rejected with the exception of milk and lime-water, and whey—that is milk with the curd removed. These were also frequently rejected. Murmurs were heard over all the valves of the heart, and the carotids were throbbing violently. It will be easily understood that when our patient

was in such a condition any specific medicines for the disease, administered by the mouth, were out of the question. Bismuth was the only medicine that was retained, and to this we sometimes added small doses of morphine.

Treatment—Under these conditions we resorted to the method of giving both medicines and nutrition per rectum. We gave tinc. of digitalis *M.* xx. and ext. ergot fld. *M.* xx., at stated intervals as we deemed expedient, carefully watching their effects. At the same time we nourished the patient by rectal alimentation, giving Wyeth's preparation of beef tea, iron and wine, milk gruel, ordinary beef tea, chicken broth, etc. We also gave pepsine, lactopeptine, maltopepsyn, etc., as the case might be, with bismuth and milk and lime-water by the mouth, as we found the patient could stand it, our object being to restore the tone of the stomach so that it might resume the duties of its office at as early a period as possible. We found that the nutrient enemata were retained for fully two hours at a time, and the functions of the bowels were not materially interfered with. We also used galvanism along the pneumogastric nerve twice a day for five minutes at a time, but what part this had in bringing about the salutary result which followed, we are not prepared to say. Hammond reports cases of cure from the constant current alone. We have to state, that after a few days of this treatment the patient was able to take gruel, beef tea and broth by the mouth. After two weeks she was able to take solid food, and the medicine partly by the stomach and partly by the rectum, as the stomach would tolerate it. Under this treatment the pulse was reduced to 100 in a few days, and became steadier, the irritability of the stomach gradually passed away, and our patient in a few weeks was able to resume her usual diet. In about six weeks she was able to attend to her household duties.

Remarks.—I. In this case we ordered absolute rest, with mustard at intervals over the irritable stomach. We believe rest to be an excellent thing, as we found that all exertion increased the pulsations in the tumor—the throbbing of the carotids and the palpitation of the heart.

II. We believe in regulating the action of the heart. This is of primary importance because the aortic pulsations behind the stomach contribute very much to the irritability of that organ. This is done with digitalis and rest.

*Read before the Ontario Medical Association, June, 1884.

III. It is important to persist in the treatment, no matter how apparently hopeless the case may be—for no case could be more hopeless than this one, and success at last crowned our efforts.

IV. As to medical treatment, we are in favor of a combination of ergot and digitalis as we found her improve more on these drugs than she did on any other remedies—at the same time we would remark that the treatment should be modified and changed so as to suit the condition of the stomach which is apt to be very irritable in this disease. The idiosyncrasies of each patient should also be respected.

Present condition of patient.—She is quite well. There are no murmurs heard over the heart—the gland is normal in size—the eyes are all right—the arteries have ceased to throb and the heart no longer palpitates—altogether the patient may be considered cured in the fullest sense of that word, and it is not very likely that we will ever have the chance of treating her for this disease again.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—Will you be kind enough to publish the following in your valuable journal :—

Clinical courses for practical physicians, comprising all the special branches, are held every month at the Polyclinic in Berlin (Germany), 30 Carlstrasse. The courses begin with the first of each month, and last a whole month, lectures being given on every working day. The number of participants is limited to six for every course. Should more than six apply for the same course, an extra or parallel course will be organized.

To all those physicians wishing to perfect themselves in a special branch, the opportunity is given to serve three months as assistants in that particular branch. Those gentlemen having served as assistants will be allowed, in appropriate cases, to conduct the extra or parallel courses.

We intend to elevate the Berlin Polyclinic into an international medical school for the improvement of physicians of every country. In order to have the courses conducted in foreign languages, assistantships will be conferred upon foreign physicians.

Yours very respectfully,

LUDWIG LOEWE,

Surgeon General, Berlin Polyclinic.

BERLIN, June 13, 1884.

To the Editor of the CANADA LANCET.

SIR,—The July number of the LANCET has just come to hand, containing a report of the proceedings of the late sitting of the Medical Council. The Council proposes to introduce an amendment to the Medical Act, giving power to levy an annual tax of \$5 or commutation sum of \$20.

Now, let us see for a moment how large a sum will be raised by this tax on our hard earnings. It has been said that there are about 2,000 practitioners in the Province; $2,000 \times 5 = \$10,000$ annually, or \$40,000 at commutation rate, a very respectable income indeed!—apart from students fees. To what purpose is this nice sum to be devoted? The published report of the meeting does not state. Is it because the Council has found \$1 per annum uncollectable, that they are now to make it \$5, and by so doing serve two purposes, collect it easier, and increase the per diem allowance of members.

In the above remarks I merely touch on the matter to bring out the opinion of the profession at large, on the proposed amendment, ere it become law. A new election is approaching, let all those who are of the opinion that this money is quite as useful in their own pockets as it is likely to be in the coffers of the Council, bestir themselves to return candidates pledged against any such amendment; and also let them bring their influence to bear upon members of the Local Legislature for the same purpose.

Yours, &c.,

J. C. THOM, M.B.

Streetsville, July 10th, 1884.

Selected Articles.

THE ABDOMINAL TRACTOR AND ITS APPLICATIONS.

Dr. Henry Hartshorne, of Philadelphia, describes in the *Medical News*, March 1st, the use of this appliance :—

Some time since, I exhibited before the College of Physicians of Philadelphia a simple apparatus for abdominal traction; having especially in view its use as an aid in producing artificial respiration. My attention had been called to the incompleteness of the means commonly employed for that purpose, by their failure in two cases of drowning which I was so unfortunate as to witness at Atlan-

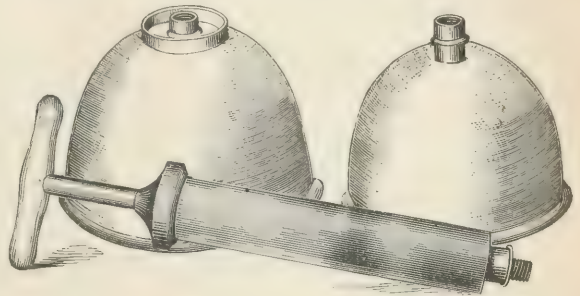
tic City, N. J. Easy experimentation on my own person satisfied me, as it may anyone, that Sylvester's method (the best in use) has very little *compulsory* power in expanding the lungs. One may, without the slightest difficulty, effect *expiration* while the arms are raised backward and far over the head, and *inspiration* while they are being brought down and pressed laterally against the ribs.

Considering the large amount of force readily exercised by the diaphragm in what is called "abdominal" as distinguished from "thoracic" respiration, it is reasonable to suppose that, in asphyxia from any cause, respiration may be prompted and assisted in renewal by *drawing the viscera away from below the diaphragm*. Such is the intention of the apparatus which I now propose to describe. It consists, first, of a tube or pump, not unlike, in shape and size, an ordinary enema syringe of the old-fashioned kind; holding, however, somewhat less than a pint, for lightness; and having a cross-piece at the handle, for greater firmness in traction. It is constructed as a *two-valve* exhausting pump; so that, by drawing upon it again and again, a firm hold may be taken and kept.

Secondly, the tube is adjusted to a large cup or metallic bowl; designed to be applied to the abdomen. I have had two sizes of bowl made, so as to suit bodies of greater and less width and stature. One bowl is seven and a half inches across its outer rim, and five inches deep; the other is six inches across, and three and a half inches in depth. Either may be affixed to the exhausting pump for abdominal traction. My first thought was to use a *one-valve* pump, so as to *alternate* rapidly the elevation and depression of the abdominal walls; but it was soon found that, unless with a pump so large as to be unmanageable on account of its weight, the lifting of the viscera by one draught of the pump will not be sufficient to answer a good purpose. By trial on a living body, I find that the exhausting pump and bowl above mentioned will take a very strong hold of the abdomen, and exert a great lifting action upon its contents.

No case of drowning or other asphyxia having come under my observation since the instrument was constructed, I have had so far to content myself with its trial on the living body, with normal respiration, and some applications of it to dead subjects. The latter, however, on account of the bodies having been semi-solidified by preservative injections, were not satisfactory in determining what such traction may do towards effecting artificial abdominal respiration. This yet awaits an opportunity of fair trial. The least that may, in my judgment, be expected of it is, that it may render valuable aid to the Sylvester method; just as *counter-extension* does to *extension* in the reduction and treatment of fractures. The two methods may be combined with perfect facility and convenience.

More positive ground of confidence appears to me to exist, in regard to the application of a similar mode of abdominal traction to the treatment of *strangulated hernia* and some forms of *intestinal obstruction*. This is not a new proposition. Authors mention it as having been put in practice by Anton Nuck, the eminent anatomist and surgeon, professor in the University of Leyden, near the end of the seventeenth century. It is said to have been a method sometimes in use by Russian practitioners; and allusion to it was made in an English medical journal within a year or two, the reference to which has recently escaped my search. Slight reflection will show that the reduction of a femoral or inguinal (of course not an umbilical) hernia must be promoted by forcibly abstracting the mass of the contents of the abdomen in a direction opposite to



Scale, one-fifth-inch = 1 inch.

that of the protrusion. This is the *rationale* of the common expedient of raising the patient's heels high above his head, which I have known to be quite effectual in practice.

Also, it is evident that if, in a case of *intussusception*, we could seize either the received or the receiving portion of the gut, and draw upon it, we should almost certainly relieve the invagination. While this is not *sure* to be done in every case by abdominal traction, it affords a greater *probability* of such a result than any other mode of treatment without laparotomy, and hence it is worthy of careful trial. My apparatus was made by A. H. Wirz, of Cherry Street, Philadelphia, and will be at the service of any practitioner who may desire to use it in fitting cases.

TREATMENT OF GASTRIC ULCER.

At the Société Médicale des Hospiteaux, April 21st, there was an interesting discussion on the treatment of ulcer of the stomach.

The discussion was opened by Dr. Debove, who remarked that the ordinary way of treating simple gastric ulcer by an exclusive regimen of milk and lime water or milk and Vichy water often fails. One of the inconveniences attending this treatment is that large quantities are required to sustain the

patient, from which irritation and even dilatation may result. The attempt has been made to give an equivalent in milk in smaller volume by using milk powder or condensed milk, but these preparations had not been successful. The same may be said in regard to meat powders so much employed in "gavage" or forced feeding, which are ill borne in gastric ulceration, and often occasion vomiting. In view of this want of success, Debore asked if it were not possible to find some other regimen, which while nourishing the patient, would suspend for a time the action of the stomach and suppress the secretion of gastric juice, whose injurious influence on the march of ulceration is universally conceded. Certain authorities have lauded the benefits of enemata of peptones, substituting rectal alimentation for alimentation by the stomach, but this does not allow the organism to be sufficiently nourished, especially if the enemata be depended on for a long time.

In view of the impossibility of suppressing the secretion of gastric juice, Debore has endeavored to modify its acid reaction by neutralizing it. The acidity of the gastric juice is so characteristic and so necessary to stomach digestion that one may truly say that gastric juice when rendered alkaline has lost all its properties. There is equal reason to believe that it is to this acidity that the gastric juice owes its power to prevent the healing of the simple ulcer. The problem then consists in finding how to so neutralize the gastric juice that azotized food may be given to patients in such a way that the digestion shall be accomplished not in the stomach, but in the small intestines. With this end in view Debore administered to his patients a certain quantity of meat powder associated with a large dose of bicarbonate of soda; twenty grammes, for instance, of the powder and ten grammes of bicarbonate at each meal time. Several trials assured him that the theory which he had adopted was correct. On withdrawing, for example, by a flexible tube the contents of the stomach in patients to whom he had previously given the mixture of meat powder and soda, he ascertained that there was no trace of peptones. He treated in this manner four patients affected with ulcer of the stomach. In all these the intolerable pain which they were suffering and the vomiting disappeared.

At the present time Dr. Debore relies on the following procedure: During the first few days he washes out the stomach to free it of acid matters it may contain. This operation has never in his practice provoked hematemesis, and is regarded as safe. He uses a soft flexible tube, whose extremity if it hit against the ulcer could do no harm. In the next place he administers to his patients three times a day, twenty-five grammes of powdered meat suspended in milk and mixed with ten grammes of bicarbonate of soda. This mixture is administered at meal time and by means of the stomach tube, as

it is very disagreeable to take in the ordinary way as food. The patient is given, besides, a quart of milk a day, rendered alkaline by lime water. The patients have been confined to this diet for several months at a time, and this treatment has never given rise to any of the symptoms which characterize what has been called the 'alkaline cachexia.'

Dr. Jaccoud moreover affirms that he has been able to give to certain patients for a very long time twenty grammes a day of the bicarbonate of soda without the least harm resulting. Charcot has also given as much as thirty to forty grammes a day without noting any cases of cachexia. If it is well established that the bicarbonate of soda long continued does not produce cachexia, it is no less true that its employment is attended with certain inconveniences. Besides its disagreeable taste, its action on the stomach is somewhat irritating, and by its decomposition under the influence of the digestive secretions it sets free considerable quantity of carbonic acid, which causes painful eructations. Another reason which has prompted Debore to seek a substitute for the bicarbonate in some other alkali is, that the former by reason of its great solubility may be too speedily absorbed, and consequently fail to sufficiently neutralize the gastric juice. He has tried to replace the soda with lime water, saccharate of lime, and magnesia. All these have their advantages and disadvantages, and he now uses that combination which has given the best results. At each meal, which consists of twenty-five grammes of meat powder well stirred into milk, he adds a small package containing a mixture of about equal parts of calcined magnesia and bicarbonate of soda. He also orders the patient to drink each day a quart of milk to which is added one gramme of saccharate of lime.—*Boston Med. and Surgical Journal*.

THE ACTUAL CAUTERY IN DISEASES OF THE JOINTS.

Mr. Henry Smith, F. R. C. S., professor of surgery in King's College, in the *Lancet*, May 11th, gives his views on this subject. He states that, whilst in former times the actual cautery had been employed to a considerable extent by surgeons, it had gradually fallen into disuse, in consequence probably of the seemingly cruel and painful nature of the operation, so graphically described by the late Sir William Fergusson in his "Practical Surgery." Since, however, the introduction of anæsthetics, by means of which this potent remedy could be applied without the horrors formerly accompanying it, the actual cautery had been resorted to without scruple, and the pupils attending his class had had recently several opportunities of witnessing the extraordinary benefits produced by its application. He desired to call attention to

two other instances of disease of the knee-joint, occurring in females, where the effects of one application of the actual cautery had been remarkable. In one of these cases the disease had been of long standing, the joint being in a state of chronic inflammation, the chief symptoms being severe pain on any attempt to move it and some swelling. After the employment of various measures, which were of little use, the actual cautery was freely applied, with almost immediate relief and ultimate cure. In the other case, that of a woman who had been suffering from chronic inflammation of the femur, which had implicated the knee-joint, and resulted in great enlargement of the bone and ankylosis of the joint, attended with most severe pain and total loss of use of the limb, no treatment seemed to be of any avail until the cautery had been freely used over the end of the femur and knee, and those present had been able to witness the effect of this agent, which resulted in immediate and permanent relief. In another case which had been before their notice, that of a young woman with disease of the hip-joint, the symptoms denoting progressive disintegration of the articulation, the usual treatment was adopted—namely, rest, extension, and local applications,—but although the acute symptoms were relieved, intense pain persisted, especially at night. The actual cautery was applied, and the effect was to mitigate the pain within a few hours and ultimately the course of the disease was arrested. Another striking instance of the good results produced by the cautery had recently been under their notice. It was the case of a poor woman who had suffered for some time from disease of the spinal column in the dorsal region. There was some curvature, very severe pain on pressure over three of the vertebræ, and latterly the woman had lost control over the bladder. After she had been kept at rest for some little time, and the more urgent symptoms had been relieved, he applied the actual cautery freely over the diseased vertebræ, and at the same time administered mercury internally so as to produce gentle ptyalism. The effects were almost immediate; pain was relieved within a few hours, the bladder symptoms were removed, and in the course of six weeks the woman left the hospital convalescent, having been previously fitted with a Sayre's jacket. In an instance also of disease of the ankle-joint in a strumous lad, where the features of the case pointed to mischief in the bone rather than in the synovial membrane or cartilage, he was on the point of amputating the foot, but before doing so he determined to apply the cautery freely. This was done under ether, and with such good results that the patient left the hospital with a stiff ankle but a serviceable foot.

Mr. Smith said he was anxious to draw their attention to one important point in connection

with this means of treatment. It should not be used in instances where acute inflammatory action existed; it would be necessary to abate the acute symptoms before using the cautery. In all the instances alluded to this had been done, and the actual cautery was then applied; in fact, as he had often pointed out to the pupils in the wards, it was in those instances where chronic inflammation was going on, threatening progressive disintegration of the joint structures, and especially those instances where constant pain was a notable symptom, that the actual cautery was such a powerful ally to the surgeon; and he strongly advised its use in such cases before resorting to more severe proceedings.

CREASOTE IN DISEASES OF THE AIR PASSAGES.—Dr. Pick, of Coblenz, says (*Deut. Med. Woch.*), that the action of creasote in consumption, recently much extolled by the French (Bouchart and Gimbert), as well as the successful experiments of Frantzel and Curschmann, induced him to employ this much discredited remedy in a series of cases, and to make a summary of the results. Creasote was given by the author both internally and externally. For external use he employed a mask which, being a modification of Hausmann's apparatus, could be worn by the patients without much difficulty, and even during the night. The creasote was dropped on cotton-wool in the mouthpiece, and was inhaled by means of deep inspirations. The apparatus has the advantage over Hausmann's that the nose remains free, and the troublesome irritation of the nasal mucous membrane is avoided. Dr. Pick gave the creasote internally either with cod liver oil, or according to the French formula: *Kreasoti, 13, tinct, gent., 30, spirit. vini rectif. ad., 250, vini Malag. ad., 1,000.* The drug was well borne by the patients both internally and in the form of inhalation, and Dr. Pick speaks of one case where there was a decided antipathy to cod liver oil, but where it was taken quite well in the above-mentioned combination. Gastric disturbances or toxic effects were seldom perceived. Among the cases treated by the author was one of croupous pneumonia passing into gangrene, thirteen of tuberculous infiltration in persons with hereditary taint, and one of sudden hæmoptysis after long-standing catarrh of the lung. The results were very good in all sixteen cases; after a short use of the drug, diminution of the cough, considerable reduction of temperature, improvement of the general health, and decrease in the expectoration quickly ensued; and the hæmoptysis mentioned above, which had not yielded to a fourteen days' treatment with ergotin, was speedily checked by a few hours' inhalation of creasote. This may, perhaps, be attributed to the styptic action of the creasote, which, besides its disinfect-

ing and antipyretic properties, coagulates albumen and contracts the capillaries. A lasting effect was, however, observed to follow the employment of creasote only in catarrh of the apex, or in commencing infiltration. In advanced phthisis, where extensive disintegration of tissue with great diminution of strength was already present, the only lasting result was the alleviation of isolated symptoms. Dr. Pick lays particular stress on the quality of the creasote, and attributes its actions only to that got from beech-wood tar, in contradistinction to the kind more frequent in commerce, obtained from coal-tar, whose qualities, so far from being useful, only set up gastric disturbance.—*Med. & Surg. Reporter.*

WATER IN THE DIETARY OF YOUNG CHILDREN
—In a communication to the *New York Medical Journal* (September 29), Dr. Rensen, of the Nursery and Child's Hospital, calls attention to the general ignorance which prevails as to the necessity of furnishing infants with a sufficient quantity of water, especially in hot weather, and whether they are brought up at the breast, or artificially. For want of this, the fluid portion of any food introduced into the stomach is quickly taken up, leaving the solids too quick to be easily digested. They ferment and produce indigestion and colic, together with diarrhoea. As a consequence of the thickened state of the blood thus produced, excretion of sweat is arrested, and a state of collapse and hyperpyrexia is developed. In warm, dry weather, babies will drink cool water every hour or oftener, if it is, as it should be, offered them. The earliest sign of the water in the system being below its normal standard is a slightly depressed condition of the anterior fontanelle. This may be present in children apparently in perfect health, yet in whom a slight increase of temperature or the deprivation of the breast for a few hours, may give rise to sudden hyperpyrexia. Attention is, however, usually first aroused by the fretfulness of the child, a moderate rise of temperature and pulse, a hot, dry skin, and a constant desire to suck. If a free supply of water be given, and nursing restricted in frequency, these symptoms will often disappear completely and quickly, but if not, collapse will soon come on. The temperature ranges from 105° to 106° F., or higher; the pulse is small and thready, numbering from 180 to 200; the skin of the body is painfully hot, while the extremities are cold; the features are pinched and sunken, with the eyes half-closed and the pupils contracted; the fontanelle is depressed, the hands are tightly shut, the respiration is hurried and irregular, and consciousness seems abolished. A child in this state will swallow water with greediness and the utmost pleasure. The treatment adopted at the Nursery has been wrapping the patient in a wet sheet, applying cold to the head, and giving as

much water as can be swallowed. The results have been very satisfactory, the child becoming quiet, and even going to sleep, while all the threatening symptoms rapidly subside. "The attention given to this point as a prophylactic measure has been followed by a diminished rate of mortality, and a marked reduction in the number of gastric and intestinal complaints. If more care was taken to give children a proper amount of water, and restricting their hours of sucking or feeding, the mortality due to hot weather would decrease, and less would be heard about the troubles of teething."

PATHOGNOMONIC SIGNS OF DISEASE.—Dr. E. G. Janeway, of New York, read a paper before the American Medical Association (*Louisville Med. News*), on "the danger of relying too much upon so-called pathognomonic signs of disease."

It is often a very brilliant thing, he said, to make a snap diagnosis, but it is not safe to do so; for many so-called pathognomonic signs of special diseases are found, on closer inspection, not to be so in reality. For instance, optic neuritis, conjoined with headache, used to be considered as a pathognomonic sign of cerebral tumor. This is not so. We know that it only means that there is some increased pressure in the brain. You must also eliminate Bright's disease of the kidneys. Volitional tremor is thought by some to be very characteristic of multiple sclerosis, but a similar condition is observed in patients who are under the influence of metallic poisons, such as mercury, and also in those who have partaken freely of alcoholic stimulants. We often find considerable difficulty in cases of coma, in endeavoring to decide whether it is of hemorrhagic or uremic origin. The variations in the temperature of the body are here a valuable help in our investigation; but they are not sufficiently certain to found a positive conclusion upon. The existence of heart murmur, or the absence of it, does not positively settle the point as to whether there is an embolus in the brain or a hemorrhage; and albumen in the urine is often associated with these lesions. The author went on to consider cases—referring to heart and chest diseases. It is not wise to rely too much upon these signs, but to take the whole bearing of the case in making the diagnosis.

Dr. Frank Donaldson, of Baltimore, in opening the discussion, spoke of cardiac murmurs. He had known of cases in which the autopsy showed marked stenosis of the mitral orifice, which had presented no murmur during life.

Dr. Janeway said that in some cases of pneumonia of slight grade, bronchial breathing is not present, and he had seen people much misled by it. In regard to mitral stenosis he thought that it could sometimes be detected by a long first sound with a slightly blubbery character, even when there was no murmur.

A NEW METHOD OF TREATING PLEURISY.—Prof. Picot (of Bordeaux), describes a new method of treating acute pleurisy when it has been found necessary to puncture. It has been his custom after thoracentesis to apply immediately a large blister over the region, to prevent, as far as possible, any re-formation of the fluid. But, in order to produce a more powerful revulsion, his assistant, Dr. Cayla, after evacuating the fluid as completely as possible, covers the affected region with cauterized punctures made by the thermocautère. These cauterizations are practiced immediately after the evacuation; they are very numerous, but a short distance from each other, and their application is followed by a powerful revulsion over the whole of the thoracic region corresponding to the diseased pleura. This method has been used several times without accident. The patients, men and women, bear it well, and the punctures are made with care that the cauterization shall not include more than half the thickness of the derm.

Mr. Picot cited in support of his method a number of favorable cases, in all of which there has been no return of the fluid, and a cure was effected in a few days. One case was particularly interesting—it was a case of acute miliary tuberculosis, with a considerable accumulation of fluid on the left side which required thoracentesis; 2,050 grammes of fluid were evacuated, and the cauterization was performed as usual. There was no return of the fluid to be detected by physical signs, and the patient dying some little time after by the progress of the tuberculosis, the autopsy showed that the pleura from which had so recently been extracted a large quantity of fluid, no longer contained any traces of it.—*Four. Am. Med. Association.*

IODIDE OF POTASSIUM IN PNEUMONIA.—Regarding pneumonia as a general disease with local manifestations, Dr. Schwarz recommended the use of iodide of potassium in six grain doses every two hours, at the same time applying an ice-bag to the chest over the seat of the pulmonary lesion. All his cases thus treated recovered, some of them within two days. Dr. Gualdi (*Gazetta Medica di Roma*, May 15, 1884) has similarly treated a number of cases, and reports most excellent results. He formulates the following conclusions based upon his experience with this mode of treatment: 1. Schwarz's method of treating pneumonia gives good results. 2. These results are even better in the case of children than in that of adults. 3. The treatment should be instituted at the beginning of the disease, for when commenced at a later stage the cure is less rapid and satisfactory. 4. The action of the iodide is exerted upon the fever and the general disease, and not upon the local lesion. 5. The iodine and the potassium become separated within the organism and each of them exerts a

special effect. 6. The action of the ice is upon the local condition. It is useful in the period of pulmonary congestion, but injurious in the stage of hepatization.—*Med. Record.*

PALATABLE PRESCRIPTION.—The best prescription containing iodide of potassium is the following:—

R Potassii iodidi.....3 ij.
Tinct. aurant. cort. recentis.....3 ij.
Ext. glycyrrhiz. rad. fl.....3 i.
Syr. simplicis.....q. s. ad. 3 ij.

Of this each teaspoonful contains five grains, and the iodide is so perfectly disguised that persons who have been accustomed to its use fail to recognize its presence. For this combination I am indebted to Mr. Julius H. Eichberg, the skillful and efficient druggist of the Cincinnati Hospital. The vehicle is eligible also for the administration of the bromide of potassium. A syrup of coffee is highly recommended to hide the taste of the iodide—fifteen grains to the ounce. The same vehicle can be used for the bromide, except in cases where the stimulant effect of coffee is to be avoided.—*Cin. Lancet and Clinic.*

ANTISEPTIC ABSORBENT SPONGE.—Mr. Sampson Gamgee showed before the Medical Society of London, April 21st, an artificial antiseptic sponge of his invention. A small capsule, containing eucalyptus or other antiseptic, was enclosed in absorbent cotton; outside of this was a layer of cocoanut fibre, and outside of this more absorbent cotton-wool; the whole being enclosed in gauze. When about to be used the capsule could be broken by a blow of the fist, and the absorbent cotton become permeated with the antiseptic. Mr. Gamgee said that these sponges could be made at a very trifling cost, and he hoped they would come into use as a cheap substitute for ordinary sponges. They possessed this great advantage, that when required for use they were certain—however long they might have been kept—to be antiseptic; and, being so cheap, they might always be destroyed after being used.

TREATMENT OF CONSUMPTION.—In the *Medical Press and Circular*, June 8th, Dr. William H. Pearce says he is continuously prescribing a combined muriatic acid, quinine and arsenic treatment to a large number of those who are of the phthisical type, but whose cases have not advanced beyond the indigestion of bodily debility stages, and, with rare exceptions, with marked benefit. His general directions to such a patient are an out-door life, all and any food to which his fancies incline him, and which include onions and pickles; also cod-liver oil, and the following mixture three times a day, after meals: R. Cinchonid. sulph., gr. xx;

acid muriat. dil., $\bar{3}$ v ; liq. arsen. hydro., m. c ; aq. maris., m. lxxx ; mangin. sulph., gr. xx ; infus. quassæ, ad $\bar{3}$ x. Twenty doses. The improvement is steady and regular, though, of course, rather slow.

INHERITANCE AS A CAUSE OF DRUNKENNESS.

—There is no doubt that *inheritance* has much to do with a thirst for strong drink, especially if we can bring the case down to a fine point, and find the child was begotten during the time either parent was suffering from alcoholism. As an example of this theory, I have a well authenticated case of inherited inebriety now under treatment at the "Home"—a gentleman, the third son of his parents, who is sorely afflicted with alcoholism. He tells me that himself and younger brother (the fourth son) have always, almost from infancy, been too fond of liquors, while his two elder brothers are strong total abstinence men, and never touch liquor ; they are also men of wealth, while the younger, who are inebriates, are poor. He tells me that he has often heard his mother say of his father, that during the first five years of their married life, he (the father) did not use liquor in any way, and would not associate with men who did. But about the fifth year after their marriage, about the time the third son was begotten, the father had many business reverses, took to drink, and died after being an habitual drunkard for several years.—*Report of Dr. J. G. Ferrell to Cal. State Medical Society.*

TREATMENT OF ACUTE ALCOHOLISM.—The following mixture is in use in the Albany Hospital, *Med. Annals*, for the treatment of the effects of acute alcoholism, to relieve nervous excitement and insomnia :

R	Tr. opii deod.,		
	Ext. hyoscyam fl.,	aa	$\bar{3}$ j,
	Chloral hydrat,		
	Pot. bromidi,	aa	$\bar{3}$ j,
	Tr. capsici,		$\bar{3}$ ss,
	Tr. aconiti rad,		m v,
	Aqua menthæ pip., ad.		$\bar{3}$ iv. M.

Sig.—Two tablespoonfuls and repeat in four hours if sleep is not produced.

A BAR TO MALPRACTICE SUITS.—A case tried not long since in one of the Western States brought up the question whether a successful suit by a physician for the value of his services did not bar any subsequent suit by the patient for malpractice, and it was held that it did. The first suit was litigated to decide the point of the value of the services, and although the charge of malpractice was not directly made as in the second suit, yet if there had been any malpractice there would, of course, have been no value to the services. The failure

to make the charge in the first suit was held to forever prevent its being raised afterwards.—*Med. and Surg. Reporter.*

SUCCESSFUL ABDOMINAL SURGERY.—Dr. Robert Battey, of Rome, Ga., (*Virg. Medical Monthly*) reports eighteen consecutive cases of ovariectomy performed by him, all successfully. He employed a modified antiseptic treatment. He insists on having the patient under his immediate charge subsequent to the operation, and concludes as follows. "The friends of a patient are by no means the best nurses for an ovariectomy case. Whilst in England I was assured that no operator who had any character to lose would venture to stake it upon an operation to be done under such disadvantages. They all require their cases to come to them, and put them into the hands of their trained nurses."

SALICYLATE OF SODA IN PHLEGMASIA ALBA DOLENS.—D. Miguel Vigar (*La Correspondencia Medica*) says that of four cases of phlegmasia alba dolens which he has had occasion to treat, in the first with the topical remedies usually employed he obtained no result attributable to the medication, since the patient remained in bed two months ; and that in the other three, having employed the salicylate of soda, in the dose of four grammes (60 grains) a day, he noticed in all, from the first day of taking the medicine, notable diminution of the fever and œdema. Neither of these patients passed more than twenty-one days in bed, and no œdema, nodosities, or thickening of the lower limb remained.—*London Medical Record.*

DIARRHŒA MIXTURE.—

R	Tinct. catechu,	$\bar{3}$ ij,
	Oil peppermint,	M. vj,
	Ext opii liquid,	M. xij,
	Mistura cretæ ad,	fl. $\bar{3}$ iv. M.

Sig.—Teaspoonful every time the bowels are moved.

A NEW TRACHEOTOMY TUBE.—Dr. Hendrix, in the *St. Louis Med. Journal* for August, describes a tracheal tube of his invention which he thinks has several advantages over the common tube, especially in the cleansing and changing. It is of ordinary tracheotomy shape with a short external tube intended to reach only through the tissue down to the trachea but not into it. Through this the long tube with the long fenestra is made to slide and is held by a friction clamp, confined by a screw in such a way as to be removed gradually, and as the screw tightens the clamp to the tube it may be retained at any depth required. It obviates the necessity of having a skilled person remaining constantly with the patient.

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & CO., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, AUGUST, 1884.

The LANCET has the largest circulation of any Medical Journal in Canada.

CANADA MEDICAL ASSOCIATION.

We trust our readers and the profession generally will remember that the meeting of the Canada Medical Association, as noticed in our May number, will take place this year in Montreal, on the 25th, 26th, and 27th of August, under the presidency of Dr. Sullivan, of Kingston. The interest in this meeting will be greatly enhanced by the presence of the members of the British Association for the advancement of science. Their meeting begins on the 27th, and several of the members have expressed their intention of being present at our meeting. Dr. Tait, of Manchester, has promised to read a paper on "Abdominal Surgery." We trust the members of the medical profession throughout the Dominion will be present in large numbers. This will probably be the only opportunity for some years to come, of seeing and hearing many of the leading scientific men of Great Britain. Certificates entitling members to return tickets at a fare of one and one-third—good from August 22nd to September 5th—may be had on application to Dr. Osler, General Secretary, Montreal, or to any of the local secretaries, viz., Drs. Bray, Chatham; Bell, Montreal; Coleman, St. John, N. B.; Black, Halifax; and Betts, Winnipeg. Members leaving Toronto by the Saturday boat at 2 p.m., or the Sunday evening train will reach Montreal in time for the opening session on Monday the 25th, at 10 a.m. The local committee has secured the Synod Hall, in connection with the Cathedral, as the place of meeting.

RABIES INOCULATION.

It is now about four years since Pasteur commenced his experiments and researches into the nature of hydrophobia, the results of which have been recently given to the public. Although the profession and scientists generally may not be very sanguine as to the grand results which this distinguished *savant* claims, yet enough has been advanced to warrant the French Government in appointing a commission of scientific men of indisputable authority to investigate the matter and to test the value of the interesting experiments instituted by Pasteur. The names of Vulpian, Villemin, Bert and Bouley are a sufficient guarantee of the character and reliability of the proposed enquiry. Pasteur in the course of his experiments hit upon the expedient of inoculating the brain of the animal with the virus of rabies. The skull is trephined with a small instrument and the virus introduced. By this method the action of the virus is much hastened, the effects being manifest in a few days, instead of from twelve to fourteen days. In fact Pasteur thinks he has in this way demonstrated that rabies is a malady of the brain. In the course of his experiments he found that the virus, after having passed through three monkeys in succession, becomes so attenuated that its introduction into a dog is harmless. But when the virus is passed through the rabbit and guinea-pig in like manner, it increases in virulence, becoming more virulent than the virus of the rabid dog. The plan proposed is to take the virus from a rabbit dying after inoculation, and inoculate this successively in other rabbits, and finally in the dog, which is thus rendered refractory to the rabies.

The test experiments proposed by Pasteur consist, first, in causing twenty unprotected dogs and twenty "vaccinated" dogs (presumably protected thereby from the poison) to be bitten by dogs in a rabid state; and, second, in artificially inoculating with the virus of rabies two other sets of twenty dogs, respectively vaccinated and unvaccinated. "The twenty vaccinated dogs," says Pasteur, "will resist the poison, and the other twenty will all die of madness."

The importance of this discovery, if true, cannot be over-estimated, but we must not be too ready to express unqualified approval and endorsement of Pasteur's views. It will be observed that he

uses, contrary to what one would have supposed, the virus from rabbits, and not the attenuated virus from monkeys. Furthermore, he does not propose to apply the virus for the protection of human beings, although we have read in the press that persons applied to him for inoculation. The experiments so far do not seem to us convincing, and we await with considerable curiosity, mingled with not a little anxiety, the report of the commission. The result of these trials can hardly fail to be largely decisive of the question one way or the other, and will be an unequivocal illustration of the value of experimental pathology. Meantime, we agree with the man who said that the best way to prevent hydrophobia was "to shoot the dog before he went mad."

THE CHOLERA EPIDEMIC.

"Eternal vigilance is the price of liberty." But little change need be made in the wording of this well known aphorism in the science of government to make it applicable to sanitary science. Eternal vigilance is the price of health. This is not only true in the sense of the life of the individual, but it is also true as regards the life of the whole people. Vigilance in sanitary matters is at all times commendable, both on the part of nations and individuals. But this is more especially true at a time of more than ordinary danger—at a time when the air is portentous of dire calamity in the near future. Such a time is the present. Cholera, that dreaded scourge of the human race, is now reveling and gambolling amongst its helpless victims along the coasts of the Mediterranean Sea. At the present writing southern France has been reached, and different centres of population are experiencing all the horrors of the plague. Where it will next appear no one can tell, for that depends on numerous modifying circumstances. It is just possible, owing to the intimate relations existing between nations, the multifarious channels of trade and travel, and the rapid movement of ocean steamers, that cholera may appear in Quebec or New York before it does in Paris. Ships will be permitted to leave infected ports, and no matter how careful health inspectors may be at such ports, there is always the dread possibility that an outgoing vessel may become a veritable messenger of death to thousands resting in self-security at a

point thousands of miles away, and this, too, in spite of the strictest quarantine. Perhaps no enemy of our race so nimbly and stealthily eludes the eye of the sentinel as that mysterious something whose terrible operations we call cholera. The knowledge of this fact affords an additional reason for vigilance on the part of all concerned.

An invasion of cholera is a thing so terrible, that governments would be quite justifiable, nay, are morally bound, to exercise care to the extent of embarrassing commerce and inconveniencing travel, to a degree not hitherto practised. A threatened wholesale slaughter of the best, as well as the worst, of a people, is something so inexpressibly appalling and calamitous that, to avert it, no material consideration should stand in the way, for a single moment. The French government, by placing itself between the dead and dying, and the living, has set an example worthy of all praise. By voting a liberal sum for the purposes of relief and protection, the French legislature only places itself in accord with the sentiments of the times, but that in no way detracts from the wisdom and expediency of the act, while it furnishes to other nations an example worthy of imitation.

We notice with pleasure that the United States government is instituting precautionary measures, having issued strict orders to its consuls at all points of danger, especially regarding vessels embarking for that country, and also by the adoption of measures of protection at home. We trust the Dominion government is not asleep and that already vigorous measures are being matured to protect our people from impending calamity, so far as human effort is capable of so doing. Not only does this duty devolve upon the central government, but also upon our Provincial governments, and upon all other authorities or corporations having the power to enforce sanitary laws. It is needless in this enlightened day to point out what measures are called for in this emergency. We may mention, however, that the work naturally divides itself into two parts—general and local. Quarantine, of course, falls to the province of the general government, and that implies a good deal. The Provincial governments have the power to enforce sanitary regulations, and in case of an invasion of the disease, may institute measures calculated to prevent its spreading. But no government will engage in the work of drainage, or

the cleansing of streets. This is the business of municipal authorities. It is well always to remember that, while the best sanitary conditions do not secure complete immunity from this, or any disease, yet cholera specially delights to dwell and revel amidst general squalor.

Dr. Covernton, chairman of the Ontario Board of Health, strikes the key-note in his letter to the local press, when he says that "thorough inspection and disinfection should be made imperative at the various ports of entry." If to this be added complete isolation of all cases that occur, there need be no fear of the spread of the disease. A pamphlet on cholera was issued by the Ontario Board of Health last year, giving full instructions as to prevention, etc., and it would be well at this juncture to republish it. So far as Toronto is concerned, we have a most able health officer, and an efficient Board of Health, and if the authorities supply the requisite funds, a thorough purification of lanes, cesspools, drains, slaughter-houses, etc., and the removal of every variety of filth may be confidently relied upon. We trust that other cities and towns in the Dominion will do likewise.

JEAN ETIENNE LANDRY, M.D.

The death of Dr. J. E. Landry, of Quebec, is announced in *Le Canadian* of June 18th. He was born at Carleton, Que., in 1815, and received his early education at St. Anne. He studied medicine in the Marine Hospital for four years, and received his license in 1840. After graduation he practiced a few years at Point Levis, and afterwards returned to Quebec. In 1854 he was appointed professor of surgery in Laval University, a position which he held for upwards of a quarter of a century. He also held the position first of surgeon, afterwards of consulting surgeon to the Hotel Dieu, the Marine Hospital, and other institutions in Quebec. He had since 1880, however, retired in great measure from active duty. For a short period he was surgeon to the 11th and 24th British regiments. Among some of the foreign honors bestowed upon him may be mentioned the following: Knight Commander of the Order of St. Gregory and St. Sepulchre, Corresponding Member of the Anthropological Society of Paris, Honorary Member of the Society D'Emulation, etc.,

etc. He had obtained great eminence in his profession and was highly esteemed by his confrères and the public generally.

AUDI ALTERAM PARTEM.—In another column we give place to a letter calling in question the proposed amendment to the Medical Act, with reference to the annual fee to be imposed on members of the College of Physicians and Surgeons of Ontario. We are of course quite willing that both sides shall have a hearing. The object of the contemplated amendment to the Medical Act, is to get over the difficulty and expense of collecting a small annual assessment fee. No doubt most members will avail themselves of the proposed commutation rates. This will not, so far as we can see, cause any hardship, inasmuch as those who have paid their annual dues regularly in the past, will require to pay only the difference between what they have already paid into the treasury, and \$20. They are thus relieved of all worry or anxiety about remitting a small sum every year. Many will regard this as a boon, so that we do not for a moment believe there will be any serious opposition to the scheme. Space will be freely given, however, to any who may desire to discuss the question on its merits. We have no objection to hear the pros and cons.

NITRITE OF AMYL IN EPILEPSY.—The editor of the *Alienist* says one method of treatment is to put a drachm of amyl nitrite in a two inch long, three drachm vial, placing a small sponge between the liquid and the cork, instructing the parent or attendant to keep the vial always accessible in the pocket, and upon the first sign of approaching spasm to withdraw the cork and apply to the nostril a sufficient time to slightly suffuse the face, and adopt the same method shortly before the time of the expected paroxysm, and several times a day when convulsive recurrences are frequent. He has had the most satisfactory results, with old and young by this method. The dose of the amyl nitrite *should be regulated by the effect produced rather than quantity, provided the inhalations are very brief. A few seconds only for an inhalation, and not oftener repeated than every six hours.*

"GROSS" MEMORIAL PROFESSORSHIP.—The Alumni Association of Jefferson Medical College has

inaugurated a movement to secure, in some medical school, the endowment of a Memorial Professorship, to be designated the S. D. Gross Professorship of Pathological Anatomy. The profession at large, the personal friends of the late Professor Gross, and others who may be interested in such an object, are cordially invited to participate in this recognition of the services and reputation of the late Professor Gross. Contributions may be sent to Dr. R. J. Dunglison, Box 1274, Philadelphia.

LOTION IN SEVERE CONTUSIONS.—The following formula of a lotion is very highly recommended by Dr. Hewson, in the *Medical Times* in cases of severe contusion. He has had large experience in the treatment of such wounds among the lumbermen in Texas, and has found it of great service :

R Sodæ hyposulphit..... ʒiv.
 Acid carbol. crystal..... ʒss.
 Glycerini ʒij.
 Aquæ Oj.—M.

A cloth well saturated with the lotion to be kept constantly applied to the part.

NOMINATION FOR ONTARIO MEDICAL COUNCIL.

—The members of the Huron Medical Association have unanimously nominated Dr. J. Campbell, of Seaforth, as a candidate to contest the territorial division of Malahide and Tecumseh at the election to be held in May next. We congratulate Dr. Campbell upon this expression of confidence from his worthy confrères, and should he be elected we feel sure their confidence will not be misplaced, as he will undoubtedly make a most able and energetic representative.

NITRO-GLYCERINE IN EPILEPSY.—This remedy has been in use in the treatment of epilepsy during the past few years with varying results. Dr. F. W. Campbell, of Montreal, in some remarks before the Medico-Chirurg. Society, reported in the *Can. Med. and Surg. Journal*, claims to have had continued good results. Even when it did not cure, it had the effect of diminishing the force and frequency of the attacks. He administers one drop of a one per cent. solution three times a day.

GYNÆCOLOGICAL.—The following caustic criti-

cism is from the pen of Dr. Clifford Allbut :—He says : “A neuralgic woman is either told that she is hysterical or that it is all uterus. In the first case she is comparatively fortunate, for she is only slighted ; in the second she is entangled in the net of the gynæcologist, who finds her uterus, like her nose, a little on one side ; or, again, like that organ, is running a little, or is as flabby as her biceps, so that the unhappy viscus is impaled on a stem, or perched upon a prop, or is painted with carbolic acid every week in the year, except during the long vacation when the gynæcologist is grouse-shooting, salmon catching, or leading the fashion in the Upper Engadine. Her mind thus fastened to a more or less nasty mystery, becomes newly apprehensive and physically introspective, and the morbid chains are riveted more strongly than ever. Arraign the uterus and you fix in woman the arrow of hypocondria, it may be for life.”

PROFESSIONAL ADVERTISING.—Our confrères down by the sea are not to be outdone in the matter of advertising. An ex-president of the Nova Scotia Medical Society (by the way presidents and ex-presidents of societies, are not the smallest sinners in this respect,) who spoke so strongly a year ago about “levelling up” (sic.) the profession, occupies half a page in announcing his “Private Infirmary” in Belcher’s *Farmers’ Almanac* for 1884. (See advertising page 24). This same gentleman has also recently issued a circular on the eve of his departure for Europe, in which he modestly states he expects to visit several of the larger special hospitals of England, Germany, and France, and to bring back such increased store of practical knowledge, together with new surgical apparatus, as may be of use to those who may seek his services.

DIAGNOSIS OF CANCER OF THE STOMACH.—Dr. Rommelaere, *Jour. de Med.* of Brussels, publishes a series of clinical observations, illustrating a new point in the pathology of cancer. In thirty-four cases investigated by him, he finds that in cancer of the stomach the amount of urea daily eliminated progressively diminishes until it is below 12 grammes (180 grains). In twelve cases of gastric ulcer the daily elimination was about 25 grammes. In studying cases, therefore, where doubt exists between ulcer and cancer a diagnosis can thus be made.

RECEPTION TO DR. JENKS.—Dr. Jenks, who formerly practiced in Detroit, but who accepted the chair of Gynecology in the Chicago Medical College, five years ago, has recently returned to his former home, on account of his wife's ill health. A grand reception was given him at the residence of Dr. Morse Stewart, at which upwards of a hundred of his former fellow-practitioners and a number of prominent citizens were present. We congratulate the Dr. upon this generous exhibition of fraternal feeling.

APPOINTMENTS.—Dr. Sheard, Prof. of Physiology, and Dr. Teskey, Demonstrator of Anatomy, Trinity Medical College, Toronto, have been appointed, the former on the acting staff, and the latter Pathologist to the Toronto General Hospital.

The following changes have been made in Bishop's Medical College, Montreal, Dr. D. D. Gaherty, Prof. of Anatomy; Dr. H. L. Reddy, Prof. of Medical Jurisprudence; Dr. J. C. Cameron, Prof. of Obstetrics; J. T. Donald, M. A., Prof. of Chemistry.

Dr. James Gray has been appointed Medical Superintendent of the Montreal General Hospital.

OMISSION.—In our report of the Ontario Medical Association, we inadvertently omitted to make mention of two interesting papers, one by Dr. Gunn, of Brucefield, on "Hysteria," and the other on "Exophthalmic Goitre," by Dr. Campbell, of Seaforth. The latter paper will be found in the present number, and the former will appear in an early issue. Both are worthy of attentive perusal.

HYMENEAL.—Dr. Sheard, Prof. of Physiology in Trinity Medical College, Toronto, has joined the great army of Benedicts, and has gone with his bride to Baltimore. He will visit the Johns Hopkins University and look into their methods of investigation and instruction in physiology and pathology. We offer him our congratulations, and wish him all happiness.

BRITISH DIPLOMAS.—The following gentlemen, graduates of Trinity Medical College, Toronto, have successfully passed their examination for the L.R.C.P., Edin.:—Drs. B. H. Scott, A. Gillespie, J. Stuart McCullough, J. E. W. Anderson, J. Stan-dish McCullough, E. A. Hall, W. J. Chambers.

HAY ASTHMA.—The approach of the "hay fever" season suggests a reference to some of the remedies which have been found serviceable in this affection. Belladonna is highly spoken of by Dr. Philips in the *British Med. Journal*. He gives one and a quarter minims of the succus in water every hour till relieved. Dr. Dobson, in the *Lancet* for May 31st, recommends the inhalation of camphor and steam. One drachm of powdered camphor is put into a vessel containing hot water and the steam inhaled for twenty minutes at a time, and repeated every hour until relieved.

NOTICE.—If the person who advertised the practice for sale in a rapidly growing town on the Georgian Bay, in the last issue of the *LANCET*, will communicate with this office he will hear something to his advantage.

TRINITY COLLEGE CONVOCATION.—The following medical gentlemen received the degree of M.D., C.M., on the 3rd ult.: Drs. M. Sutton, Jas. Henderson and W. Nattress.

REMOVAL.—Dr. A. Sanford, of Upper Kennetcook, N. S., has removed to Brooklyn, N. Y., where he intends to establish himself in practice.

THE British Medical Bill has passed the second reading and there is now no reasonable doubt that it will shortly become law.

THE death of Cæsar Henry Hawkins, of London, Eng., Sergeant-Surgeon to the Queen, is announced.

Books and Pamphlets.

ECZEMA AND ITS MANAGEMENT, based on the study of three thousand cases. By L. Duncan Bulkley, A.M., M.D., New York. Second Edition. New York: G. P. Putnam's Sons. Toronto: Williamson & Co.

This is the second edition of this work by the well-known authority on skin diseases. He has had large practical experience as a dermatologist and has turned it to good account. The work before us is based on the study of three thousand cases of the disease under consideration, which have been analyzed with praiseworthy diligence. He has studied the relation of eczema to asthma

and has come to the conclusion that the latter is a condition of the pulmonary tract similar to that found on the skin in eczema. He also believes eczema resembles gout and rheumatism in certain respects, and is dependent on a similar unknown cause. In the treatment he lays great stress on dietetic and hygienic measures. He believes that arsenic is often of value in chronic cases, but used indiscriminately it may do harm. Cod-liver oil is well adapted to most cases. For eczema of the anus and genitals, which sometimes proves so intractable, he recommends hot water, as hot as can be borne, applied for about five minutes, the parts then pressed dry with a soft napkin, and some ointment containing tar and zinc immediately applied to exclude the air entirely. It is upon the whole a most admirable book, but is somewhat encumbered with matter which is not essential to the elucidation of the subject.

SECOND ANNUAL REPORT OF THE ONTARIO BOARD OF HEALTH, FOR THE YEAR 1883.

This report gives evidence of a considerable amount of labor on the part of the various members of the Board, but in the shape in which it is, we fear the outcome will be of little practical value to the general public. A few small pamphlets containing practical information on sanitary matters, circulated broadcast, would be of infinitely more service than this cumbrous report, which will be read by nobody, and referred to by very few outside of the small body of sanitarians. It is useful merely as a record of the labors of the board—an account of their stewardship, and as such is not wholly without interest. It seems a most difficult task to arouse any degree of interest in the public mind regarding sanitary reform. Even the approach of cholera seems hardly sufficient to arouse municipal authorities to a sense of their duties and responsibilities.

THE POPULAR SCIENCE MONTHLY for August, 1884. New York: D. Appleton & Co.

The August number of "The Popular Science Monthly" contains several interesting papers, among which may be mentioned two articles on the future of religion. The first, "The Ghost of Religion," is by Frederic Harrison, and is an attack on Mr. Spencer's "Unknowable," and the second, "Retrospective Religion," is Mr. Spencer's reply. "The World's Geyser-Regions," by Dr. Peale, with several full-page illustrations, is also very instructive. There is also a curious and interesting article on old-fashioned arithmetic, under

the title of "The Mystic Properties of Numbers." The Editor's Table is occupied with a discussion of the relations of "Science and the Temperance Reform."

Fifty cents a number, \$5 a year; with the CANADA LANCET \$7 per annum.

CLINICAL CHEMISTRY, by Charles H. Ralfe, M.D. Illustrated with 16 engravings. Philadelphia: H. C. Lea's, Son & Co.

THE DISSECTOR'S MANUAL, by H. Bruce Clarke, M.B., and Charles B. Lockwood, M.B., F.R.C.S., Eng. Illustrated with 49 engravings. Philadelphia: H. C. Lea's, Son & Co.

ELEMENTS OF SURGICAL PATHOLOGY, by Augustus J. Pepper, M.B., F.R.C.S., Eng. Illustrated with 81 engravings. Philadelphia: H. C. Lea's, Son & Co.

The above are three of a series of "Students' Manuals," issued by this well-known publishing house. They are octavo size, well printed, and handsomely bound. The object of these works is to furnish students and practitioners with a concise account of the subjects presented. The authors have apparently kept this object well in view, and the result of their labours is very satisfactory.

REPORT OF THE MEDICAL SUPERINTENDENT OF THE ASYLUM FOR INSANE, TORONTO, FOR THE YEAR ENDING 30th September, 1883.

From a casual glance at the superintendent's report, we find that the death rate has been very uniform for several years past, and considerably below the average mortality in asylums, being about $4\frac{1}{2}$ per cent. This is a fair estimate of the healthfulness of the inmates, and evidence also of favorable sanitary surroundings. The recoveries have been 65, out of 162 admissions during the year, or 40 per cent., or $7\frac{1}{2}$ per cent. of the entire population. The superintendent estimates the number of insane people in this province at 2,800 or 1 to 714 of the population, of which 90 per cent. are under asylum care. This is a much better showing than that of our neighbors across the line.

Births, Marriages and Deaths.

On the 10th ult., Charles Sheard, M.D., M.R.C.S., Eng., Professor of Physiology and Pathology, Trinity Medical School, Toronto, to Virna, eldest daughter of E. Stanton, Esq., Toronto.

On the 2nd ult., at Uniontown, Kansas, the beloved wife of Dr. A. L. Fulton, Editor of the *Kansas City Medical Record*.

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1885.

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Original Communications.

FIBRINOUS POLYPOID UTERINE TUMOUR—SECONDARY HEMORRHAGE REMOVAL OF TUMOUR.*

BY A. D. LEITH-NAPIER, M.D. ETC., DUNBAR.

NARRATION OF CASE.—Mrs. M., wife of an actor, æt. 22, pale, little, blonde; secundipara; was easily and naturally delivered of a healthy female child on 30th May, 1881. The placenta came easily and was entire; the membranes untorn; in size the placenta seemed rather small, but appeared quite healthy. Mrs. M. originally a weak, fragile woman, of nervous temperament, had been confined of her first child sixteen months prior to the second delivery. She nursed her first baby nine months. Lochia lost colour on fourth day; mother nursed child; milk sufficient; pulse and temperature normal, average 80 and 98°. In consequence of her husband's pecuniary embarrassment at time of her confinement, she had no regular nurse, and possibly exerted herself more than was prudent from the very first. However, she did exceedingly well up to 9th June, (the eleventh day); she rose on that day, but did no house work. In the evening she carried her little boy across the room, and thoroughly washed him; she felt very tired after doing so. Between three and four hours after this bleeding began. I was sent for about 11.30 p.m. On visiting I found my patient reclining in an arm chair, in a profound faint; no pulse at wrist; face pallid as death. The quantity of blood lost was very great; but as she had been sitting up, fully dressed, when hemorrhage commenced, it was impossible to estimate how much, even approximately. The whole of her clothing from below the waist was saturated; the chair, covered with leather cloth, contained a large pool, and from it the blood had streamed over the floor. The faint lasted for

several minutes after my arrival, although on my seeing her she was immediately placed flat on the floor, with her head low. Upon recovering consciousness, the clothing was removed, and she was gently lifted into bed. On examination the vagina was filled with clots, as was also the lower uterine cavity; two fingers could be easily introduced within the os. The uterus felt about the size of a foetal head. By external and internal manipulation many clots were removed, the uterus contracted, and was fixed by a pad and roller. The following was prescribed—

R Ext. Ergotæ fl. ʒi
Tr. Hamamelis ʒss.
Aq. ad. ʒij.—M.

Sig. Two teaspoonfuls at once, and one teaspoonful every two or three hours. Cold water cloths were applied to the vulva for an hour and half. After remaining an hour I felt satisfied that bleeding was checked and left. During the night, and next day, several small clots were passed, and about six or eight napkins used. On 11th June two or three cloths were required; on the day following the discharge ceased. Mrs. M. continued to nurse her baby, but was strictly enjoined to maintain the recumbent position in bed. On 13th June, about 2 p.m. I was again sent for. I found the patient sitting up in bed. She was very nervous; bleeding recommenced with much severity about half an hour before. Fully twenty napkins were used; half of the number perfectly soaked. The vagina was cleared of all clots; two fingers introduced *in utero* and some clots, half the size of a hen's egg, removed. The uterus was not nearly so large as on the former occasion. I learned she had only taken her mixture for 48 hours. She had been wholly in bed; but had been "obliged to sit up frequently to attend to baby, as she was fretful." A full dose of ergot was given, and the former mixture ordered to be taken every four hours, also whiskey frequently.

14th June—Clots passed in early morning; discharge very moderate. As her strength was seriously impaired, she was advised to wean her baby.

15th and 16th June—Color of discharge brownish, only one napkin in the twenty-four hours.

17th—Lochia brighter; two napkins through day. 19th—Color almost gone; one napkin in twenty four hours. 22nd—Small quantity of "slimy discharge." 24th—Feeling well; rose; no

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discharge. 25th—Very slight discharge. 26th—Rose about noon; up two hours; bleeding began necessitating two or three napkins; went to bed, but bleeding continued profusely; after a time it gradually ceased; there was then “a very free clear watery discharge; about 8 p.m. a large blood clot was passed.” I visited about 10 p.m., by this time the bleeding had almost ceased. P.V. examination; after removal of some clots, a pyramidal fixed mass fully occupied the cervix; the uterine tissue was soft, and it was possible to introduce two fingers within the os. The surface of the mass felt rough. The uterus could not be felt distinctly in the hypogastrium. In consequence of the feeble state of the patient, a prolonged examination was deemed inadvisable. The vagina was plugged; full doses of ergot and witchhazel ordered. The handling of the tumour caused little pain; patient stated she “had severe pain in the belly to-day, before and after the bleeding.”

27th—Feeling pretty well. To ascertain the exact nature of the tumour, a sound was used; it passed two and-a-half inches within the uterus. The diagnosis being clear; the tumour was fixed by forceps, and twisted off, with little difficulty. The growth was, roughly, the size of a hen's egg, and was encapsuled in a distinct membrane.

2nd July—Patient exceedingly agitated, on account of a drunken row in lodging-house, but no recurrence of hæmorrhage. The subsequent history contains nothing of note; in fact, from the removal of the tumour she progressed most satisfactorily. On the 13th July she was able to take a longish walk.

REMARKS—The whole subject, and especially the pathology of fibrinous uterine tumours requires so much consideration that I sent the tumour for minute examination to Dr. Woodhead, who after careful observation reported as follows:—“The tumour appears to consist of two factors, a piece of placenta and large masses of coagulated blood. Near the surface of the tumour is an appearance somewhat like that very roughly washed in on the other side. The pink being the placental structure in which are a number of connective tissue, and it appears to me, muscular fibres. The villi are covered with a layer of flattened epithelium and are cut in various directions. In some parts of the section there are numerous cells apparently from the wall of the uterus which are undergoing the

coagulation necrosis, *i. e.* are with the fibrine forming a coarse net work, the coarse strands being formed by fibrin and the periphery of the cell, whilst in the centre of the mesh is frequently seen the nucleus with a small quantity of granular protoplasm. This cannot be accidental, as it occurs at several points and in every specimen I have examined. It is very like the net-work formed in diphtheria. The remainder of the tumour consists simply of coagulated blood which has been thrown out at different times, for in some cases the coagula are much more distinctly seen than in others. Delicate bands of fibrin, form a net work more or less dense and perfect, in which lie the coloured and a few colourless blood corpuscles.” Dr. Woodhead, who was most kind in thoroughly examining the tumor, wrote me further that he considered the cells to be “epithelial, not muscular, in character,” “those lining the uterus and probably some of the glands.” I was most anxious to have the opinion of an expert microscopist, as I have found very great confusion in literature regarding the variety to which some of these tumours should be referred.

On macroscopical examination the tumour which was fully as large as a hen's egg, appeared to me more like a small fibro-cystic growth than a fibrinous polyp. I noted that what seemed to have been a cyst was for the most part occupied by a reddish bloody stratum, this stratum evidently having been formed from extravasation of blood within the cyst; the membrane forming the cyst wall was well developed. There had evidently been discharge of part of the contents of the cyst, as the dense coagulated blood and fibrinous appearance, together constituting the main part of the tumour, did not wholly occupy the investing membrane. My rough microscopical examination, before proper hardening, shewed bands of tissue somewhat like fibro-muscular structure, but this has been more exactly described in Dr. Woodhead's report.

Having determined the morbid anatomy of the growth, its pathogenesis next demands notice. The most natural theory is that a growth shewing evidences of placental structure is more or less a product of the placenta. It is well known that poly-poid formations are a frequent result of one or more pieces of placenta having been left *in utero*. It is also equally well known, that at times portions

of retained placenta may sustain existence for a considerable time ; not only existing *in utero* but so to speak persisting in vitality. For example, in one case a lady was sent to the seaside for the recovery of her health and the stoppage of hemorrhage, some weeks after abortion. A more severe attack of bleeding led to an examination ; when a piece of placenta fully the size of a walnut was found lightly held in the cervix ; on its removal bleeding ceased. But in the above case we have more than simple placental structure ; a distinct evidence of cell formation, which cells were evidently derived from the uterus, and also some muscular fibre. The presence of smooth muscular fibres in the placenta has been described by Ecker and Kamenew ; but denied by subsequent inquirers. Stricker states that his own researches demonstrate their presence to be constant in the external layer in the placenta uterina. I think it probable that the muscular fibres here described were uterine. In addition to the placental, there was the aforementioned hemorrhagic portion encapsuled in a distinct membrane. We may assume that the interpretation of the "coagulation necrosis," which Dr. Woodhead remarks on as notable, is, that post-partum the vitality of the growth was checked, and that nature was preparing for its expulsion. So that we may premise that the tumour had an ante-partum existence distinct from the foetal placenta. Small fibrinous coagula intimately blended with the projecting thrombi at the placental insertion, are quite commonly found in the bodies of puerperal women. But larger coagula also, the result of repeated hemorrhages, the size of a walnut, either of a round shape, or flat and lobulated, which may also project into the uterine cavity like a cockscomb, are by no means rare. These cases only are very rare where large fibrinous coagula of a polypoid shape are seated at the normal placental insertion and project with their obtuse end into the cervix or vagina. A fibrinous polypoid of that kind—the free polypus hæmatoma of the uterus (Virchow)—consists of coagulated fibrin including a nucleus of coagulated blood. Polypoid formations, from retained placenta, may undergo further modifications. Upon the pieces of placenta blood may be deposited in the way just mentioned, and a fibrinous polypus is formed with a pedicle of placental tissue, or the retained cotyledon may become bloodless, firm and hard,

and assume a shape corresponding to the uterine cavity. This forms the so called placental polypus.

A few words regarding the changes in effused blood. It may remain liquid for some time, or quickly coagulate. Formation of cysts may take place, not so much in the effused blood as in the surrounding parts. Those which are at first ragged and torn, undergo more or less of inflammation, which ends in the formation of a solidifying blastema ; this fibrillates and passes into the state of more or less perfect fibrous or areolar tissue, and thus forms a capsule or cyst enclosing the now more or less altered blood. Rokitansky describes the later appearance of the lining as like a delicate serous membrane—Hæmatoma. The effused blood may undergo a different kind of change, in consequence of absorption of its watery parts, and become in this way a kind of tumour, termed an hæmatoma, classed with new growth ; but there is no doubt that it is a simple result of hæmorrhage, and this for three reasons—(1) that it presents no higher structure than that of fibrine ; (2) that it is generally devoid of vessels ; (3) that it does not appear to increase by growth in the proper sense of the term. The inner parts ultimately undergo some form of degeneration, while the outer form a fibrous investment. An hæmatoma thus formed (*i. e.* in the substance of new tissues, etc.,) being essentially a fibrinous mass, may undergo certain other changes—cretification, melanic pigmentation, perhaps ossification—(Jones and Sieveking). Some consider it doubtful whether such changes as bone formation, etc., can take place from blood effusion. Without expressing an opinion on this point, I conceive it might be well to retain the name 'hæmatoma' to bloody tumours in loose tissues *e. g.* the vagina, vulva or scalp. As a mere question of pathology the so-called polypoid uterine hæmatoma is diverse from the condition found as a result of rupture of vessels and effusion into sub-mucous connective tissues as found in the one, and beneath the aponeurotic or pericranial layers in the other. No authority, so far as I know, has however observed distinct characteristic cell formation similar to the above described appearances, in a simple hæmatoma. That the tumour was in great measure of this nature is true, but, I think it would be erroneous to regard it as simply a hæmatoma ; and while it is plain that the growth was partly placental, it seems to me equally evident that its de-

velopment was inconsistent with the theory that it was derived from a portion of the main placenta. I think, if we believe in its formation from a placenta succenturiata, which some considerable time before labor had become wholly uterine in its connection, and at one time or other had undergone certain structural changes already referred to, we may best realize the genesis of the polyp. Twenty years ago Professor Hodge, of Pennsylvania, in his "Principles and Practice of Obstetrics," fully described the nature of placenta succenturiata. Dr. Eastlake has also (Obstet. Transact. Lon.) written regarding this anomaly. Schröder writes "sometimes the placenta is divided even in simple pregnancy. Two or more, even seven placenta have been observed; and at the side of a larger, several placenta succenturiata occur. These formations can easily be explained from the development of the membranes—some of the villi of the chorion not inserted at the place of the decidua serotina retain their vessels and enter into vascular communication with the decidua vera. If this does not take place the enlarged villi form the so-called placenta sparia."

POINTS OF PATHOLOGY are here also of interest. Unlike certain allied tumours, no special blood vessels supplied it; this was unnecessary as the growth had been, at first, in the same relation to the uterine circulation as the placenta normally is; but afterwards received a more direct blood supply from a uterine vessel or vessels. In connection with this, the grave bleedings which occurred when the tumour became partially detached can be understood more clearly. Generally the formation resembled that of an aneurismal clot, in which laminae are formed by the variations in the rate of the coagulation or succession of coagulations, and in the paler portions the definite formation of fibrine gave rise to similar microscopical characters. But the existence of an internal cyst containing clear fluid requires notice. We know, that in not a few cases, cysts of various size are formed on the concave side of the placenta; the connective tissues between the chorion and amnion are raised cyst-like, and are lined by flat epithelium, whilst the placental portion assumes a rough, shaggy appearance, and is covered by fibrinous deposits. These cysts are thin transparent vesicles containing a yellow, or reddish-opaque, thin fluid. It is supposed that they are formed from apoplectic cen-

tres. One writer describing the "fleshy" species of polypi says: "they sometimes contain a cavity filled with fluid resembling mucous or lymph. This variety is however a most likely one to be absorbed during pregnancy." Paget's description of the formation of cysts in loose-textured fibrous tumours is also apposite: "they may be due to a local softening and liquefaction of part of the tumour, with effusion of fluid, or an accumulation of fluid, in the interspaces of the intersecting bands, but in other cases it is more than probable that their production depends on a process of cyst formation." Returning to the present case, it is probable the cyst was adventitious, that is the walls were formed by the condensation of the connective tissue of the part; it is also likely that the cystic fluid may have been serous, derived from the effused blood. If so the external investing membrane must have been, as we would expect, of earlier formation than the small internal cyst. The minute examination of the tumour shows that the different "probable sources" for the formation of uterine polypi, viz.: the connective tissue of the uterus, placental growths, and blood coagula, were all involved; and, as is remarked above, as a consequence of pathological changes in loosely bound together fibro-muscular tissue (?) a cyst may be formed. In further illustration of the benefit of sometimes "thinking twice before you speak once," or in other words making out the morbid anatomy ere you settle your ideas of a case, I may mention that various considerations caused me to regard the polyp as of post-partum formation on the one hand, and as possibly an ante-partum fibro-cystic growth on the other. The theory of post-partum development was suggested by the clinical facts that the placenta was removed with the greatest ease and seemed perfectly entire, there was neither uterine flaccidity nor hemorrhage post-partum; it seemed probable, if the tumour had existed in a condition of latency, it would either have been expelled with the secundines or have given rise to smart bleeding. On the contrary the uterus contracted well, and no symptoms of a growth were then noted. The puerperium was normal; involution seemed natural, the patient having "slimy discharges" for four days antecedent to the first mentioned bleeding. The post-partum formation of the body from a retained blood-clot seemed borne out by the symptoms. As has been already mentioned, poly-

poïd growths are not infrequently observed when parts of the placenta are left behind. Schröder perspicuously points out the time at which hæmorrhage is likely to occur—"it may be early, sometimes not till after the first week, more often after the second or third." But the placenta appeared to be wholly removed. I have paid some attention to secondary hæmorrhages, and judged the first bleeding to be due to the cause I have described as "imperfect thrombosis," (*Obstetrical Journal*, No. xlvii. Feb. 1877). The patient had unduly exerted herself on the 11th day after delivery, involution having seemed normal previously; it was believed, that as a consequence of the exertion, one of the imperfectly thrombosed veins became partially open, and we might with fair grounds assume the formation of an hæmatoma as a result; theoretically, this having a well established uterine connection might become encapsuled in a layer of fibrinous connective tissue. It is evident that some thrombotic dislodgement actually did occur as shewn by the enormous bleeding. The remedies employed favoured vascular contraction; yet on the 15th day hæmorrhage recurred; it was considered probable that the thrombus then became freed, and the separated polypus developed. From this time to the 28th day the blood-oozing was like that of sub-involution, or like surface bleeding of a polyp. The first, and only needful argument against this theory is the morbid anatomy; further, in accepting it, it would be necessary to believe that a polyp with such anatomy could be formed from blood clot in thirteen days. The other theory, viz.: submucous fibroid or fibro-cystic, was based on the ground that while fibrinous polyps are rare, and if present during pregnancy likely to cause abortion, or become absorbed, yet the existence of such has been recorded. Cystic growths are mostly cervical; and developed from the Nabothian glands or utricular follicles. But these follicles also exist near the openings of the Fallopian tubes, in the fundus, and upper part of the body; and granting an abnormal condition of the mucous lining, and a soft dilatable condition of the uterine walls, as was highly probable from the personal history of the patient, it was not impossible to conceive the tumor's formation in one or other of these ways. The examination of the growth put both theories quite out of court. The polypus was antepartum; but the post-partum influences, and the

enlargement it received from secondary hæmorrhage demand attention. I do not think unless there had been undue exertion that the hæmorrhage would have been so serious; in saying so I would point out the existence of the dual causes of bleeding, secondary hæmorrhage from the site of the polypus, and also from the imperfect thrombosis of an adjacent vein. To recapitulate, bleeding occurred on the 15th day, I conceive *not* from the vessel which was covered by the tumour, or at any rate from it only partly, most from a neighbouring vein. On the 28th day, when the polypus became loosened, blood gushed from the vein it had previously pressed on, and by covering, plugged; this bleeding was most profuse. The expulsion of the tumour from the uterine cavity was preceded by the discharge of clear watery fluid. After the partial detachment of the growth from the body of the uterus, a large recent blood-clot was expelled; this probably was the result of bleeding from the site of polypoid insertion. A practical point is, that, a firm blood-clot acts as an intra-uterine irritant assists in the production of contractions, and hence aids involution. An ordinary experience in cases of miscarriage of twins at separated periods, is the formation of such a clot. After one fœtus has been parted with it is not impossible that the other may reach full term. But this is very unusual; irregular involution or partial uterine atrophy takes place; thrombi are separated from certain veins; large bleedings occur. If appropriate treatment is employed a clot may form and bleeding cease, the uterus enlarges perceptibly thereafter; the same process of hæmorrhage, decrease in size, clot formation and increase, may be repeated again and again, until the second fœtus is naturally or artificially dislodged. In the case under notice, the large blood clot was probably formed on the 26th June. It is to be observed, that after the escape of this clot, and the descent of the tumour within the cervix, bleeding ceased externally; the cervix was plugged by the polyp; nor was there evident internal hæmorrhage, neither collapse nor increased size of the uterus being experienced. We must recollect that the personal and parturient history of the patient favoured uterine weakness; she was a very pale, fragile, anæmic, little woman, frequently insufficiently nourished; she had barely sixteen months between her confinements, had nursed her first child fully nine months, so that she continued

to nurse two months after she became pregnant. Altogether apart from the polyp, she was a most likely subject for secondary hæmorrhage or subinvolution. With the history given, we may readily suppose how easy it was, with an original abnormality, for the tumour to develope.

THE DIFFERENTIAL DIAGNOSIS is very interesting, as, if my view is correct, we have here a combination of sub-involution, secondary hæmorrhage from irregular or imperfect thrombosis, and a polypoid tumour of placental origin. The early diagnosis pointed to secondary hæmorrhage, as the early puerperium was one of evidently good involution; the lochia lost colour on the 4th day; she was permitted to rise on the 9th day; and it was only after unusual exertion on the 11th day that bleeding began. Yet despite the foregoing observations, there must have been sub-involution, as it was possible to introduce two fingers within the os on the 11th day; the bleeding could not have caused such relaxation; had involution been normal, the os would have been almost closed; my experience agrees with authority that the os is normally closed on the 12th day. The uterus, prior to the removal of clots, was as large as a foetal head; now it seems likely that the faint was most important in arresting the hemorrhage, not the occlusion of the os by a clot; so that we may believe that this bleeding was extremely rapid as well as severe. Several cloths were used on the following day, but only two or three on June 11th; next day there was no discharge. On the evening of 13th bleeding was profuse; the os was still patulous, but the uterus much less in size. The probable cause of this attack was, she had been sitting up in bed, and had neglected her medicine. The subsequent account of slight flow on June 15th and 16th, a little more on the 17th, and its gradual disappearance afterwards indicated involution. The bleeding which was so alarmingly profuse on the 26th, was clearly due to the new source of danger, the partially loosened growth. On this occasion the uterus was not felt in the hypo-gastrium except by bi-manual examination. Such irregular bleedings are met with in chronic inversion, but in acute post-partum inversion the history is different; this condition supervenes suddenly and with it we have hemorrhage and collapse. Partial inversion might occasion similar bleedings, but the organic condition would be explanatory, when the polypus

was forced into the cervix it had much the feel of an inverted uterus. I was strongly reminded of one case I saw some years ago, with Dr. Nellis of Fraserburgh and the late Dr. Fiddes of Aberdeen, of chronic partial inversion; in many respects there was much similitude. The pain in handling an inverted uterus is much more marked; the roughness, said to pertain to inversion as distinct from polypus, was in the foregoing case of little help; the tumour by no means felt smooth; but the encircling band of uterine tissue was more symmetrically circular, and the relations of the vaginal parietes to the cervix more perfectly defined. However it was not until I had cautiously passed a sound $2\frac{1}{2}$ inches within the uterus, that I felt justified in removal of the tumour. It is all very well to write in one's study of the "clear differences," but in this case at least there was nothing to prove that the body was not an inversion, which had been gradually formed and was eventually protruded, until the sound was used. From prolapsus the tumour was distinct, it occupied the neck, and the neck could be felt. With prolapsus there can be little risk of confusion, even although there should be an opening in the polyp, unless the latter occupies the vagina very fully. I am aware of the possibility of complications of polypus with prolapse and inversion; but there seems here no need of further reference. Nor do I think the "book" differences of polypus from vaginal hernias, cystoceles, or malignant affections require discussion. In chronic cases it is doubtless valuable to bear these in mind, but not with a narration like the above. The intra-uterine situation of the growth obscured diagnosis. Montgomery, fully thirty years ago, wrote "fibrous tumours formed in the substance of the uterus may thence descend, pass through the os, and form an ordinary pediculated polypus in the vagina." To him also we owe the fact that a "large polypus may make its first appearance immediately after delivery. Even with the additional facilities for diagnosis and knowledge we now possess, I think most will agree that until interference is clearly indicated, the policy of non-intervention is wisest. I fancy few would care to dilate and explore a recently parturient uterus, which had ceased bleeding, and judging from the discharges was undergoing involution. Had the polyp not appeared when it did, I would then have explored the uterus more thoroughly. I well know

that in all obscure cases of uterine hemorrhage an exhaustive examination is a hundred-fold less dangerous than is popularly believed. I have known cases where the impregnated uterus submitted to every abuse with impunity, even to an insertion of 10 grs. of lunar caustic to stop a supposed inflammatory condition, and, when profuse bleeding still continued, the artificial dilatation of the os revealed the true cause, a retained foetus and an inflamed chronically enlarged uterus! Viewing our present case retrospectively, one might think had the os been dilated, the whole thing would have been cleared up much sooner; yet, although with the authority of Matthew Duncan to justify us introducing a carbolised exploring hand within the uterus shortly after delivery, and with my personal experience of the benefit of the practice, I would not consider a case of secondary hemorrhage, with os contracted down to two fingers' breadth, a suitable one for this measure, until all others had failed; and that the case diagnostically seemed so far one of this description must be patent. Cervical tears, which have recently—"British Medical Journal, Oct. and Nov. 1881,"—been a subject of discussion, as regards their frequency and treatment, between Montrose Pallen, and Henry Bennet, might have been included in differential diagnosis. These are seldom a consequence of natural labor in such subjects as my patient, and as a matter of fact there were none. Bleeding from varicose veins in the cervico-vaginal region is either tolerably early discovered, or so slight as to require little attention. It seems impossible to misjudge either of these conditions so greatly as to confound them with secondary hemorrhage proceeding from the interior of the uterus.

TREATMENT has in part been touched upon. The primary indications were to check the flow and keep the patient living; the details have been described. Exactly the same treatment is required for secondary hemorrhage and an intra-uterine growth, up to a certain point. As Churchill said "by these means some good may be done, just sufficient perhaps to enable the patient to wait for the descent of the polypus, with rather less risk than if nothing had been done. He however regarded ergot as a beneficial remedy of a special nature. I think the witch-hazel tincture, ordered with ergot, a most useful addition. I have had much satisfaction with this drug in all classes of

uterine hemorrhage; even in malignant disease, it is fully equal, if not superior, to any remedy in restraining bleeding. A combination of hamamelis, with ergot and strychnia, and ferruginous tonics, combined with quinine is all in the way of medicinal agents likely to be of use. The long subject of removal of polypi by means of the various media employed, galvano-cauterics, ecraseurs, ligatures, canula, polyptomes, screws, scissors, or bistouries, need not now occupy us; it was found practicable to twist the tumour off after fixing it firmly; torsion, the simplest method of all, was found easy and satisfactory. There was no bleeding, and the operation was almost painless. The subsequent treatment was simply good nourishment, tonics, and rest. So well did these fulfil their aim, that on the 13th of July the patient was able to take a longish walk without fatigue.

[We are indebted to Dr. Aubrey Husband of Edinburgh, author of *The Students' Hand-Book of Forensic Medicine*, for the above interesting paper.]—ED. LANCET.

ABSTRACT OF A CLINICAL LECTURE ON A CASE OF THE "JUVENILE FORM" OF PROGRESSIVE MUSCULAR ATROPHY (ERB'S "DYSTROPHIA MUSCULARIS PROGRESSIVA").

BY JAMES STEWART, M.D.

Professor of Materia Medica and Therapeutics, McGill University, Montreal; Physician to the Montreal Dispensary; Director of the University Dispensary for Diseases of the Nervous System.

GENTLEMEN,—The patient whom I exhibit to-day, through the kindness of my friend, Dr. Wilkins, presents in a very marked degree all the essential features of a disease which has only recently been described. The case is one of what Erb calls the "Juvenile Form" of progressive muscular atrophy.

The patient is a male, aged 21 years. His occupation, up to the time he was compelled to cease working from his present trouble, was that of a farm laborer. His complaints are, weakness of his back and legs. He first noticed this weakness three and one-half years ago. At that time he experienced difficulty in dragging his body after his feet when getting into a carriage or in ascending a stair. He could, at this time, raise his feet without difficulty, but to move his body, he found it necessary to use his hands to drag

himself along. About two years ago he first noticed that he was very apt to fall, and on attempting to rise from the horizontal position he found it necessary to use his hand to drag himself up. He never suffered from any serious illness. He attributes his present trouble to a fall which he received three and one half years ago. On careful enquiry, however, he acknowledges that for a long time previous to this accident, he disliked ascending a stair, because he found it both difficult and tiresome. Two and one half years ago he received a second injury; on this occasion a weight fell on his head, rendering him insensible for half an hour, and giddy and stupid for several days. His parents are dead, but cause of death is unknown. He has a brother living and in good health. Had no sisters. As far as he knows there has been no similar trouble to his in any of his relations.

Present Condition.—You will notice the peculiar gait which he assumes when he walks across the floor: 1st, he walks with his feet far apart; 2nd, he walks on the front part of his feet, the heels being raised from the floor, and 3rd, the gait is of a more or less waddling character. Nothing abnormal can be found in connection with the circulatory, respiratory, digestive or genito-urinary systems. There are no symptoms of any affection of the brain or cranial nerves.

On stripping the patient the marked difference in the size of certain muscular groups is at once noticeable. In the upper extremities, the contrast between the well developed muscles of the fore-arms and the atrophied ones of the upper arms is very striking. The circumference of the thickest part of the upper arms is an inch less than the fore arms. A still greater disproportion exists between the muscles of the thighs and those of the legs, the circumference of either calf being an inch greater than the circumference of either thigh at the thickest part. The following muscles of the upper part of the body are in a state of more or less complete atrophy: The pectoralis major and minor, of each side, are considerably atrophied, especially the costo-sternal portion of the former. The lower half of each trapezius has almost entirely disappeared. There is scarcely a trace left of the rhomboids. The latissimus dorsi of each side is very much atrophied, as is also the whole group of the spinal extensors. The biceps of each

arm is greatly wasted, and what there is left of it is in a state of active contraction, preventing the full extension of the arms. The brachialis anticus of each arm is also in a state of advanced atrophy; the triceps is only slightly affected. The coraco-brachialis, the supra and infra spinati, as well as the deltoids, are normal. None of the muscular groups in the fore-arms or hands have suffered.

In the lower extremities the following muscular groups are in a state of more or less complete atrophy: The glutei of both sides, and the ilio-psoas. The quadriceps of each thigh is more extensively atrophied than any other group in the lower extremities. The peronei of the right side are considerably atrophied, while those of the left side have escaped. The calf muscles are hypertrophied. When the patient is in the erect posture there is marked lordosis. All the atrophied muscles are firm. They are not the seat of any fibrillary twitchings. The patient is quite unable to raise himself from the horizontal to the erect position, even with the aid of his hands. He, however, can accomplish this by getting a support to his chin, and thus using the muscles of the neck to drag his body upwards. The patellar reflex is absent. The plantar reflex is exaggerated. While the cremaster and abdominal are normal on the right side and absent on the left. The epigastric reflex is present, but the scapular is absent. The atrophied muscles do not respond to the faradic current. They are *not*, however, the seat of the degeneration reaction. Sensibility is normal. There is no interference in the vesical or rectal reflexes.

You will at once notice the striking difference there is in the patient before you, and the one* whose case we enquired into last week, and whom most of you have seen. When comparing these two cases, it is at once observable that we have to do with dissimilar clinical pictures, although they are both frequently described as one and the same disease. The following are the marked points of difference between them: 1st, they differ as to the localization of the atrophy. In the patient affected with the spinal variety of the disease, the atrophy commenced in the small muscles of the hand, in

* The patient referred to is a man, aged 37, who has the ordinary spinal variety of progressive muscular atrophy. The wasting commenced three years ago in the small muscles of the left hand.

the interossei, thenar and hypo-thenar groups. The wasting is confined to these small muscles. In this patient the atrophy affects the trunk muscles principally, while the hand muscles are perfectly free from any form of wasting. They differ also as to the condition of the affected muscles. In the spinal case they are soft and flabby, while in our patient here they are firm, hard, and have a knotty feeling. In the man previously seen, the atrophied muscles are the seat of fibrillary twitching, while the muscles in this boy's case are free from these fibrillary movements. Another marked difference is that in the case of the spinal form there is neither true nor false hypertrophy of the muscles, while there is here, especially in the calf. Other points of difference are the ages at which they make their appearance. The spinal form is essentially a disease of advanced adult life, while the juvenile form is seldom or never seen after the twentieth year. They are both slowly progressive diseases; the juvenile is, however, much slower than the spinal variety. In the latter the periods of intermission are comparatively short and seldom, while in the former they are long and frequent. They differ also as to the complications that may arise during their course. Last week, when we were examining the patient affected with the spinal form, I pointed out to you that there was marked trembling of his tongue when he protruded it. This is sufficient evidence that there is commencing bulbar paralysis in his case, and is the beginning of a series of symptoms that will before very long lead to a fatal ending. In the patient before you no such complication exists. In all the cases of the juvenile form of progressive muscular atrophy described up to the present, no such complication has existed. Secondary sclerosis of the pyramidal columns is not infrequent as a result of the changes that take place in the spinal form. It does not occur in the juvenile form. When we come to discuss the pathology of the disease, it will then be clear to you why these complications are so frequently present in the one case and never present in the other. Another marked point of difference between these two forms of atrophy is the fact that one is much more amenable to treatment than the other, the juvenile form being much more likely to have a favorable ending than the spinal.

They differ also in their pathology. In speaking

last week of the appearances found post mortem in the spinal variety of the disease, I mentioned that the essential change was a slowly progressive obliteration of the multipolar cells in the anterior horns of grey matter of the spinal cord. The local muscular changes were simple atrophy of the muscular fibres. There is no increase of connective tissue, no deposition of fat, and no hypertrophy of the muscular fibres. Now in the juvenile form the changes are wholly seated in the muscles. The multipolar cells of the anterior horns of grey matter remain free, as do also the peripheral nerves. The muscular changes consists in atrophy of the muscular fibres, with here and there fibres which have undergone hypertrophy. In advanced cases hyperplasia of the connective tissue is very marked, and lying between the connective tissue fibres is seen only a small quantity of muscular fibres in an advanced state of atrophy, which, however, still retain their transverse striation. The most important change is the hyperplasia of the interstitial connective tissue, and next to this is the deposition of a more or less quantity of fat. It is probable that the increase in the muscular fibres is the first phase of the morbid change, and that the later appearing connective tissue hyperplasia gives rise to atrophy of the muscular fibres. These changes, as we will presently discuss, are essentially those found in cases of pseudo-hypertrophic muscular paralysis, and the so-called hereditary form of progressive muscular paralysis. This hereditary form of muscular atrophy has been described by Friedreich and others, but it is essentially the same disease as we are now considering. When the disease is hereditary and sets in about puberty, the muscles affected are those of the upper arms and trunk, while if it sets in during childhood the atrophy is principally confined to the muscles of the lower extremities.

The disease commonly called pseudo-hypertrophic muscular paralysis, differs but little, if at all, from the disease with which the patient before you is affected. Clinically, the only difference appears to be, that in the pseudo-hypertrophic paralysis, we have lipomatosis, while in the juvenile form of muscular atrophy, hypertrophy is not necessarily present, and if present it is true and not false. If this is the only difference it is quite plain that it would be better to describe the juvenile form of muscular atrophy as being sometimes attended

with a true and sometimes with a false hypertrophy of the muscles, rather than describe two separate diseases. Pathologically there is no difference between them. They are both myopathic and *not* neuropathic disorders. All the recent autopsies in cases of pseudo-hypertrophic muscular paralysis agree in the particular that no changes in any portion of the spinal cord are present. The changes found being confined to the muscles and differing in no way (except in a great degree of lipomatosis) from those described as being present in cases of the juvenile form of muscular atrophy. Changes have been described as being found in cases of the pseudo-hypertrophic paralysis in the ganglion cells of the anterior horns, but this was some years ago, and before the much improved methods of the histological examination of nervous tissue were known. Seeing that in a number of recent cases examined by such competent observers as Recklinghausen, Schultze, and Ross, where improved methods were made use of, it follows that little or no value can be attached to the alleged changes found by the observers of even a few years ago.

Erb is a firm believer in the essential identity of these two diseases. Speaking of the juvenile form of muscular atrophy he says * "there is a particular form of disease of the muscles which consists partly in hypertrophy with subsequent atrophy of the muscular fibres, partly in hyperplasia of the interstitial connective tissue with more or less lipomatosis. Whether the changes in the muscular fibres or in the connective tissue is the primary event, or whether they are simultaneous appearances has not yet been definitely settled. There are no changes in either the peripheral or central nervous system. It is a very chronic and slowly progressive trouble. Clinically the disease is characterized by affecting in the upper part of the body, the pectoral, the trapezii, latissimissimi dorsi and other shoulder muscles, the muscles of the upper arm, while those of the forearm and hand escape. In the lower part of the body the muscles that suffer are those of the abdomen and the extensors of the back, the muscles of the thigh, calves, and the peroneal group. Cases of this disease in the past have been mostly described as ordinary cases of

progressive muscular atrophy. A few as pseudo-hypertrophic muscular paralysis and hereditary muscular atrophy. If the disease appears in the earliest childhood, and if there is no lipomatosis it is what has been called hereditary muscular atrophy. If there is a high degree of lipomatosis, especially of the lower extremities it is what has been called pseudo-hypertrophic muscular paralysis. These three, hitherto separately named affections, are in reality one and the same disease. It is quite a distinct disease from the spinal form of progressive muscular atrophy." It follows therefore, according to Erb, that there are two distinct forms of progressive muscular atrophy—a neuropathic form and a myopathic form. In the patient whose case we examined into last week, we had a good example of the neuropathic or spinal form. The patient before you now is a good example of the myopathic form. For the former or neuropathic form of the disease Erb proposes the name "*Amyotrophia Spinalis Progressiva*," while for the latter or myopathic variety of the disease he suggests the name "*Dystrophia Muscularis Progressiva*."

TREATMENT.—Before this patient came under the care of Dr. Wilkins, the atrophy had made such progress, that it was hopeless to expect benefit from any form of treatment. Where the disease is however seen early, there is fair grounds for hoping that in a small number of cases, arrest of it or even recovery may follow well directed treatment. As already mentioned, this form of muscular atrophy is more amenable to treatment than the spinal variety. There are very good grounds for believing that both forms would not be so fatal if more systematic and scientific attempts were made in their treatment. Physicians, as a rule, when they diagnose a case of muscular atrophy, pronounce it both "interesting" and "incurable." Seldom is even the attempt made to prevent the further progress of the degeneration. In the present state of the therapeutics of this subject, it is not possible in the very great majority of cases to prevent the progress of the disease. The few cases that have yielded to treatment are a sufficient proof that in the near future we will be much better able to combat this degenerative process. I would strongly advise you in all cases of progressive muscular atrophy, but especially in that form of the disease under consideration, to make persistent efforts to cure. The only therapeutic means of any promise is

* Erb: Ueber d. juvenile form d. progressiven Muskelatrophie u. ihre Beziehungen zur sogen. Pseudo-hypertrophie d. Muskeln-Deutsches Arch. f. Klin. Med. xxxiv. 5 u. 6 p. 467.

electricity, especially galvanism. The galvanization of the atrophic muscular groups should be performed very gently, otherwise the process may be quickened in place of retarded. It should be continued until it is quite clear that it is useless. Should it be of no effect, faradization of the affected muscles, or even general faradization should be resorted to.

EPIDEMIC CEREBRO-SPINAL MENINGITIS*

BY A. WORTHINGTON, M.D., CLINTON, ONT.

I desire to present for your consideration a brief history of an outbreak of epidemic cerebro-spinal meningitis, which took place in the county of Huron early in the year 1872, and in connection therewith some ideas in reference to its treatment. The outbreak occurred at Clinton about the latter part of December, 1871, or the 1st of January, 1872, and was termed in the neighboring towns, "the Clinton malady." It continued in and around Clinton the remaining part of the winter, and the greater part of the following summer. In other parts of the county, cases continued to occur as late as the fall of 1873. The localities visited by this epidemic appeared to be confined principally to the vicinity of streams and lowlands, carrying with it the idea that the specific poison might possibly emanate from that source. The idea was suggested to me by a Toronto medical friend. Mr. John Netton Radcliffe has written more fully on this subject than any other author to which I have had access. He says, "Locality and soil do not exercise any manifest influence over the disease. It has been observed on low grounds, high lands, and on soils of the most varied character indifferently." Sanitary regulations and precautions appeared to have very little influence in this epidemic. The rich and poor were visited alike—the well-fed, well-housed, well-clothed suffered equally with the poorly-fed, housed and clothed. According to Mr. Radcliffe the reverse obtained in certain outbreaks, as that on the Lower Vistula, where the "prosperous classes suffered to a much less extent from the malady than the poor and miserable, who were subjected to privations, and

much foulness of persons, dwellings and atmosphere." Mr. Radcliffe again says, "There is not any constant or common relationship between any insanitary state, and the appearance of the disease. Neither foulness of house and its surroundings, nor the atmosphere, whether from putrid emanations, or from over-crowding, nor impurity of any other kind, has any determinate relation with epidemic cerebro-spinal meningitis." Since the discoveries of Pasteur, Koch and others, it appears quite probable that a germ cause may yet be found for the disease, when some future outbreak provides the opportunity. The attack in many cases was exceedingly violent, causing death in from 24 to 48 hours, death being always preceded by profound coma. Mild cases, which were easily controlled, and terminating in convalescence, were quite numerous. Two cases were observed, which ran 36 and 68 days respectively, ending fatally. The disease was almost invariably ushered in with rigors, more or less severe, and accompanied or followed by pain in the head, sometimes of such a terrific character that the patient continued to cry out until unconsciousness relieved him of sensation. Pain along the spine was noticed as being very severe in only a few cases, but was nearly a constant symptom. Retraction of the head was rarely absent—in some very severe, in others very little. Vomiting was among the early symptoms, but ceased when the disease was fully established. Delirium was a constant attendant in all severe cases; arterial tension was invariably deficient, the pulse being usually abnormally slow, but often frequent towards the end in fatal cases. The temperature in all the cases observed was above normal with one exception. Respiration was irregular; in bad cases, "sighing and labored" according to severity. The treatment, if commenced early, seemed more likely to be satisfactory than if begun later on. Observation has led me to think that epidemic cerebro-spinal meningitis is not necessarily so fatal as is generally supposed. I have, however, never seen any case recover where the patient had passed into a state of stupor for over two to three hours.

In the treatment of epidemic cerebro-spinal meningitis, the removal of all the hair from the head as closely as possible—even shaved—appears to me to be the first essential in all cases of severity. The application of cold to the head is cer-

* Read before the Ontario Medical Association, June, 1884.

tainly the next (except in cases of collapse or approaching collapse), for without this application, the case may be left to take care of itself, as it certainly will, but it is needful to use the cold cautiously, guarding against the too sedative effect on the already weakened heart, at the same time using sufficient to control and reduce the engorged condition of the vessels of the brain. Blisters to the back of the neck were of great benefit, probably by producing exaggerated circulation near the brain, also along the spine in case of severe pain and spasm of the spinal muscles. Cold was applied in these cases at the same time as the blisters. It appeared to me to be of the utmost importance that cases of this disease should be seen at the earliest possible moment. Treatment delayed beyond two to three hours after the supervention of stupor, appeared to be useless, as I have not known any case to recover under such conditions. Of medicines, only two were used—aconite and morphia—others might be equally good, but I had not tried them. The two named I had tried and knew what they would do. Aconite controlled the circulation and reduced the temperature, when necessary; morphia seemed to have a marked effect—under its influence the patient became more quiet and got absolute rest; *it appeared to do more, to have a curative effect.* In illustration of this idea, I may mention the case of the housekeeper of Mr. M——, farmer, in the township of Tuckersmith, who had been suffering for several days with spasms of the muscles of the neck and back to that degree, that during the spasms she rested on her head and heels, her back being raised several inches from the bed, she being unconscious while the spasm lasted. The relief, when the spasm was over, was very little, as the retraction of the head was constant and very distressing, and drawn back as much as it could be apparently. When taking nourishment, she could only put some in her mouth, and then push it along down the œsophagus with the thumb and fingers, on account of the muscles of deglutition being stretched to that degree that she was unable to use them. These spasms occurred every 15 or 20 minutes, and lasted two or three. She also had cystitis. A solution of morph. sulph. gr. i, to ʒi. of water), was prescribed, a teaspoonful to be given every third hour as long as needed. I saw her first on the 18th May, 1872, and on my

second visit on the 21st, she was quite free from spasms and evidently convalescing. So beneficial was morphia in that terrible disease, that the thought has occurred to me that it *might, like quinine in ague*, yet be found to be a germicide. In sporadic cases I have always pursued the same course of treatment, except, perhaps, in using less morphia, with the same result. I have selected the following four cases, as each was a little different from the other.

CASE 1.—S. S——, æt. 28, cooper, was attacked on the evening of the 23rd March, 1872. I saw him about 8 p.m. Pulse 68, temp. 99, resp. normal; said he felt very sick. I prescribed a febrifuge, and directed a mustard and water foot bath, and to go to bed. About 1 a.m. I was sent for, and found him in a state of stupor, quite unconscious, moaning, and very restless. On enquiry, I was told that in about half an hour after I had left the previous evening, he was seized with a severe chill, which lasted nearly an hour, and during the chill severe pain in the head came on, and so sudden and terrific was it, that his first exclamation was, "Oh! my head!" The pain continued to increase till about 12, when he became unconscious. His pulse was slow, labored and feeble, and his face, arms, hands, body, legs and feet, all were cold, and he was so restless that he could only be kept in one place a few minutes, when he would attempt to rise, perhaps stagger and fall unless held. No heat could be detected in his head, and he uttered no cry, but moaned continuously. It was not easy to know what to do for him. I, however, had his legs from the knees to the ankles, covered with plasters of mustard, and a heated quilt wrapped closely around him, then bottles of hot water and heated bricks kept as closely around him as it was possible to do in his restless condition, and a large blister placed on the back of his neck. As far as possible this course was followed till about 7 a.m., when reaction appeared to be slowly taking place. His movements now became more natural, and he seemed somewhat conscious that there was something wrong with his legs, as he tried to get at them, when he suddenly exclaimed, "Oh! my head!" As he merged towards consciousness, he complained so piteously of his head, that I bled him to about 4 oz., which seemed to ease the pain. I had previously cut the hair from his head, and now began

to apply cold water moderately. His temperature never rose above $101\frac{1}{2}$, and his pulse was unnaturally slow, and very compressible, ranging from 60 to 80. Before night his reason had returned. He now complained of pain along the spine (rachialgia) very much, and there was considerable retraction of the head. The spinal pain and tenderness were treated by blistering and cold. On the third day he said he felt sufficiently strong, and was sent by train to Goderich, where Dr. McLean attended him some three or four weeks before he entirely recovered.

CASE 2.—H. S.—, æt. 27, labourer, got intoxicated, and lay out over night, June 30th, 1872. In the morning he felt chilly and had a bad headache, and vomited several times. To relieve his head he put a piece of ice in his hat, and lay down upon the ground in the sun. The pain had increased so much by noon that his mind began to wander and I was sent for. I found him lying on the far side of the bed and he appeared to be in a high fever as his face was very red. I asked him if he could get over near me where I could examine him, and I should say that it took him five minutes to accomplish the task. He afterwards told me that he remembered when I went into the room, but nothing after. Pulse 113, temp. $103\frac{1}{2}$ F., resp. hurried. He remained delirious for about a week, and during that time there was pretty constant retraction of the head. I had the hair closely cut from his head, and bathed with water in which plenty of ice floated; the first application seemed to produce a shock, but after a few minutes he did not appear to notice it. A blister was applied to the back of the neck and the following prescription given:

R Morph. sulph. grs. ii.
Ext. aconiti. fl. m. x.
Aqua ℥iv.—M.

Sig.—A teaspoonful every two hours.

His diet was principally milk, no solid food being allowed. The temperature fell in a few hours to $101\frac{1}{2}$ and did not rise above that again, but came down gradually to, and below normal. The aconite was discontinued after his pulse and temperature were well under control. The morphia was continued till reason returned, then changed to quinine and generous diet.

CASE 3.—Mrs. F., æt. 33, was taken down April 24th, 1872. She had been for several weeks tak-

ing care of her children, who one after the other had taken the disease in a mild form and lastly her husband, who was just recovering, when the attack came, and but for her exhausted condition would probably have been mild. A chill—not very severe—was the first instalment, followed by vomiting, confusion of intellect and delirium. The pulse from the beginning was feeble and very compressible, ranging from 65 to 110 with a marked want of arterial tension. The temperature ranged from $100\frac{3}{5}$ to $103\frac{1}{5}$, being higher in the early stages. Respiration was variable, sometimes hurried, then sighing and irregular. The vomiting ceased on the appearance of delirium. The bowels required but little attention during the attack. On the third day a thick mottled eruption was noticed, purpuric in character, the size being from a pin's head to that of a split pea—the large ones being of a dark purple while the smaller ones were of a reddish cast. Large and small were thoroughly intermingled. Pain in the head, neck and along the cord, especially in the dorsal region, was constant. In a later stage cystitis made its appearance and caused much trouble and anxiety. Still later she suddenly became blind and remained so for about twenty-four hours—this I attributed to nervous exhaustion. She had been taking quinine every two hours, but by some oversight of the nurse it was omitted for about twelve hours during which time she lost her sight. The treatment from the first had to be supporting; aconite was given very cautiously and for a short time only. Morphia was continued through to the end. Her hair was cut off except a little on the front of the head, and cold kept constantly applied. Her neck and the upper part of the spine were repeatedly blistered, and cold applied as constantly as possible. Quinine was given early and continued until she was able to be about the house. Paralysis of the right arm remained for about three months, when sensation and motion were gradually restored. Duration of attack was 50 days.

Mrs. H. B.—, æt. 26, was confined on the 25th April, 1872. Prior to confinement there appeared to be strong evidence of albuminuria, and my suspicions were fully confirmed on making the usual test. Her accouchement passed without trouble, and the kidneys gradually resumed their proper functions. Her progress was satisfactory up to 3rd May, when symptoms of some other

trouble appeared, but what it was I could not tell. There was a slight chill and slight reaction, pain in the head and back, but not severe. There was no vomiting, retraction, nor eruption. Pulse 92, temp. 100½, resp. seemed a little hurried, no abdominal tenderness, the kidneys were secreting the proper quantity of urine, and the albumen had nearly disappeared. There was no puffiness of the face, nor anasarca. The lochia had given no trouble. The pain in the head continued much the same, and on the 5th her mind began to wander occasionally, the pulse became more frequent and feeble, but the temperature did not vary much till towards the end, when it fell to below normal. No lesion of the heart or lungs could be discovered, and I could arrive at no other conclusion than that the poison of the then prevailing epidemic had secured a permanent footing in her system. She gradually sank and died on the 20th May, 25 days from her accouchement. Morphia was given and her neck blistered; tonics and stimulants and the best of nourishment were provided. No cold was used in this case.

REMARKS—The remarkable features in case No. 1 were the severity of the attack, the approaching collapse, and the rapid manner in which he rallied from what appeared to be a hopeless condition. He had uttered no sound but moaning during the five or six hours I was with him, until the exclamation Oh! my head! I confess I am at a loss to explain the rapid changes which took place in this case. In case No. 2 there was the curious fact that the nerves of motion were nearly paralyzed, as it took the patient fully five minutes to move from one side of the bed to the other, but after his hair had been removed, and the ice water applied for some time, he recovered the use of his limbs very fully, for in his delirium, and when his brother was off his guard, he sprang and seized his brother by the throat and was very near strangling him. Case No. 3 was in several points a remarkable one: first, on account of the severity of the attack, which would probably have been mild but for her exhausted condition at the time. Second, the mottled appearance and abundance of the eruption which lay beneath the cuticle. Third, the supervention of cystitis, which helped to complicate the difficulty; fourth, loss of vision, and fifth, paralysis of the right arm. I have placed Case No. 4 in the list of those cases which were certainly epidemic spinal

disease, because I could find no reason to place it anywhere else. The insidious character of the attack would seem to favor the idea that a specific deadly poison had entered the system probably through the same channels which we now charge germ poison with entering to produce puerperal peritonitis.

TWO CASES OF STRANGULATED FEMORAL HERNIA.

BY J. E. BROUSE, M.D., BROCKVILLE, ONT.

CASE 1.—May 13th, 1882, I was sent for to see Mrs M.—, in consultation with Dr. Lane, of Mallorytown, Ont. Her son, who came for me, stated that she had a lump in left groin, that there had been no passage through the bowels for some days past, and that there was frequent vomiting of fecal matter. On arriving, found patient to be a somewhat stout, fresh, bright-looking lady aged 58. She was the mother of a large family, and had always enjoyed good health. Pulse 100, firm, not very compressible, but regular; temp. 101½. She said she had been ruptured for several years, but had not worn a truss, as the tumor was small, gave no trouble, and was easily reducible. Two days previous, however, while lifting, she experienced pain in the part and felt a sickening sensation, and on examining the swelling, found it to be larger than before. Dr. Lane was called in. He had given opium and tried taxis as fully as he dared, but without success. I had her placed on a well cushioned table, and, while under chloroform, had lower extremities elevated and flexed, and endeavored to effect reduction, but was also unsuccessful. The tumor was the size of an ordinary egg, and quite painful. The abdomen was tympanitic. While Dr. Lane continued the anæsthetic, I proceeded to operate, by an incision 2½ inches long in the axis of the tumor. A thick layer of fat necessitated cutting deeply before reaching the sac, which was much inflamed and very dark. After dividing the stricture at the upper and inner angle, found adhesive bands so firmly formed, that, although I separated them as freely as I could, it was impossible to return the sac. It was accordingly opened on a director, exposing a very dark, inflamed knuckle of intes-

time, which passed readily into the peritoneal cavity. Three sutures, embracing the entire thickness, including the peritoneum, were passed, and dressings of carbolized lint and an oakum pad applied. A hypodermic of morphia was given, and patient placed in bed. No bad symptoms whatever supervened. Flatus passed the second day, and the bowels were freely moved by an enema the fourth day. She made a speedy recovery and is now alive and well.

CASE 2.—Nov. 1st, 1882, was asked to visit Mrs. T—, a lady 67 years of age, who had been taken suddenly ill, Oct. 25th, a full week previous. For several years she had been in bad health and quite feeble, so as to be unable to do anything in the way of house work. Oct. 25th, when going out of the door she slipped, and at once felt sick and experienced pain in the left groin, but did not say anything about it to her sister or family. In a day or two the pain increased, and she began vomiting, the bowels being obstinately constipated. Her sister, to help her on satisfactorily, gave her salts and castor oil, even repeating the dose. I was not sent for until the lapse of seven days, notwithstanding that stercoraceous vomiting had been going on for five days. The woman was greatly exhausted and looked so badly that I almost feared attempting an operation. The tumor was not larger than a walnut, but very painful, and the skin red. Giving her a hypodermic of $\frac{1}{4}$ gr. morphia, and obtaining the assistance of Dr. Vaux, who gave the chloroform, I tried reduction without avail, and operated at once. The sac appeared almost gangrenous, being nearly black. Without attempting to return it, I slit it up, exposing a small knuckle of intestine, in nearly as bad a state as the sac itself, though saw no actual sloughing. I was in doubt as to the propriety of returning it to the abdomen, but knowing the very great recuperative powers of both the peritoneum and intestine, and believing that, in her exhausted state, an external opening would prove fatal, the bowel was replaced and the wound closed. On Nov. 3rd, flatus passed, and the next day a copious motion of the bowels, which continued daily till her death, Nov. 8th. All tenderness over the abdomen passed away, and all tympanitis, but the nausea and vomiting continued in spite of every effort, and she died of exhaustion the 8th day after the operation.

These cases, especially the second, show the wonderful recuperative powers of the intestinal and peritoneal tissues, and I have no doubt that had Case 2 not been such a feeble person, with strength exhausted by stercoraceous vomiting before, and chloroform vomiting after operating, she would have recovered, the operation itself being a success.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—I am pleased at the position you assume towards some of the changes proposed by the Ontario Medical Council. Changes made by that body in former times were so frequent that one would need to have the minutes of their proceedings always at hand to assure himself of the legality of his position in almost any given case. It was hoped that the present Council would amend all that, and to a great extent they have done so, and it is therefore much to be regretted that the change of which you very properly disapprove, namely, the compelling of graduates in Arts to pursue a four years' course in medicine, has been made. Our profession is certainly not over-crowded with men of scholarly attainments, and we have always felt that every inducement compatible with a thorough medical course, should be held out to young men about to enter the medical profession, to encourage them to graduate in Arts before commencing their professional studies.

To place a gentleman who has passed through an Arts' course, and taken the degree of B.A., on a par in the matter of study with one who has just quitted the farm or the workshop, is certainly not in accordance with the dictates of experience. Sixteen years' teaching has convinced me that on an average the Bachelor of Arts will acquire as much professional knowledge in three years as one who has not had such a course of training will in four; and besides this, we all know that after the M.D. has been obtained, the man who has also had the training of an Arts' course is much better qualified to fulfil many of the duties which in after life devolve upon the active and respected medical man. I take the average as a rule, and do not ignore exceptions, which are conceded to be the accompaniment of all rules. Apropos of this matter I may

quote a pithy little extract from the *Queen's College Journal* for June—

"It is a significant fact that the Medicals who succeeded this year in taking University prizes are graduates in Arts. The prizes be it noted, were given for essays upon subjects in connection with the medical course. Theorists may maintain that a physician does not require an Arts education, but it is facts and not theories that for the sober-minded are trumpet-tongued. While it would be probably too much to require that every M.D. should be a B.A., as it would be to require that every Reverend should be a B.A., yet as the requirement is being at least generally fulfilled in the latter case, so it should be in the former. The spirit of the times is happily pointing in that direction. Queen's has begun to agitate for a higher standard for matriculation in medicine."

We hope, however, that with the object in view of promoting a higher standard of general education in our profession, such an amendment as the one under discussion will never become a permanent law, unless as a compensating rider they make it compulsory on every medical student to pass a matriculation examination equivalent to that for the degree of B.A.; but this would be asking too much, and hence we ask for a continuance of the old *regime*.

Another change we object to is the imposition of an annual tax of \$5, instead of \$1, upon every registered practitioner while we receive no corresponding value. Raising money in this manner for the purpose of stocking the rooms in which the Medical Council meet with a library and museum, does certainly not commend itself to the profession at large, inasmuch as our representatives are sent to Toronto for the purpose of legislating in behalf of our professional interests, and not for the purpose of refreshing their minds by perusing the tomes of a library and examining the specimens in a museum. We have been waiting patiently year after year to see some legislation that would bring under control the manufacture and sale of the many nostrums that flood our land; that would restrict or prohibit the misleading advertisements of shameless adventurers; that would enforce a proper code of ethics amongst qualified practitioners, and provide for the disciplining of those who habitually transgress it; to restrain druggists from their almost universal custom of prescribing for patients, etc. etc.; but we have hitherto waited in vain. Until our Council can show us some practical work, beyond the modifying of curricula, and the transferring of the subjects of medical study from one part of the course to another, and back again, I for one most emphatically protest against

paying any more than we pay at the present time. Let them turn their attention to clearing away some of the impostures and annoyances to which both the laity and the profession are subjected, and then we will hail the labors of the Medical Council with gladness and bid them God-speed in their laudable efforts.

Yours truly,

THOS. R. DUPUIS.

Kingston, July, 1884.

Reports of Societies.

ONTARIO BOARD OF HEALTH.

The third quarterly meeting of the Provincial Board of Health was held in Toronto on the 31st of July, Dr. C. W. Covernton in the chair. The fore part of the day was taken up with matters of routine, the secretary's report of work done, etc. Replies were read to the circulars sent out to local boards, some of which showed considerable interest in sanitary matters, while others were the reverse of what should be expected. Pamphlets on cholera were distributed in large numbers. Correspondence had passed between the Board and the Dominion Government regarding the precautions which were being taken by the quarantine officers at ports of entry to prevent the introduction of infectious diseases. The replies, though courteous enough, were far from satisfactory.

The chairman read a report on epidemics, in which he alluded to the absorptive powers of milk, and the dangers arising therefrom. He gave instances of outbreaks of typhoid fever and other infectious diseases which had been directly traceable to this source.

The secretary was instructed to communicate with the railway authorities, recommending that they provide dry earth closets on all cars.

The second day's session began at half-past ten a.m. The secretary read a letter from Dr. Brown, of Galt, stating that the manufactories on the east side of the Grand river were making offensive deposits in that river, and stating that he had taken steps to force the owners to stop the nuisance. He wished to know if the Board would support him in this action.

On motion of Dr. Cassidy, a Committee was appointed to enquire into the evils of baby farming, and suggest a remedy.

The Board then went into Committee of the Whole to consider the report which was to be handed to the Lieutenant-Governor concerning the precautions which, in the opinion of the Board, should be taken in case cholera should break out

here. The following is the substance of the regulations which were recommended :

As soon as danger has become imminent, the Board shall ask for a grant to be set apart by the Government sufficient to enable the Board to pay a medical executive officer in each town in the Province, and to meet the expenses incurred in taking precautions against the spread of the epidemic. These medical health officers will be executive officers of the Board ; and where it is found possible, the officer of the Local Board of Health shall be chosen for the position. He shall report to and act in accordance with the instructions of the Board.

On the approach of the first case of cholera the medical health officer shall at once remove it to the isolation hospital, and shall take every measure for the disinfection of linen and clothing worn by sufferers, and if necessary destroy them. He shall be careful to destroy any food which has begun to decay.

In regard to the quarantine stations which shall be provided by the local Boards of Health, all persons who may have been exposed to the infection shall be detained until such time as the period of incubation shall have elapsed, and shall be permitted to go only on being thoroughly disinfected by fumigation.

If any municipality be a port of entry from infected districts, the medical executive officer shall make a strict inspection of said vessel before any passengers, luggage, or freight from it be allowed to land ; and where any affected or exposed persons are found on board they shall be dealt with in the manner above indicated. And further all personal effects or other exposed luggage or freight shall be thoroughly disinfected before being landed.

Wherever cholera exists in any Province or State adjoining Ontario, from which railways enter the Province, the medical executive officer shall be given the full powers of a quarantine officer as far as can be exercised under the provisions of municipal or provincial laws. He shall examine all trains suspected of containing cholera, making thorough disinfection. The medical executive officer may by arrangement with the railways, board the trains when some miles outside the Province, in order to avoid unnecessary detention of trains.

Should cholera appear in this Province or in any Province or State adjoining this Province, the medical health authorities shall, under the direction of the Provincial Board of Health, carry out the recommendations contained in the pamphlet No. 14, issued by the Board.

Dr. Oldright then read a report on the prevalence of typhoid fever at the Kingston Insane Asylum. He had found the ventilation and drainage defective and the water tainted.

A letter was received from Mr. Prust, of Hali-burton, complaining of the nuisance of sawdust deposits in the lake. The chairman and secretary will take steps to assist the local Board in abating the nuisance.

In the evening session, Dr. Yeomans presided in the absence of Dr. Covernton. Upon enquiry, it was found that many municipalities had not formed local Boards under the Act, and the secretary was instructed to notify the clerks of the municipalities, and that in case the law was not complied with, the Provincial Board would appoint members of the Local Board, as provided for in the Provincial Health Act.

The secretary was also instructed to inquire through the proper official channel what precautions the Dominion and other Provincial authorities were taking to prevent the introduction and spread of cholera and other zymotic diseases.

Dr. Cassidy and Dr. Bryce were appointed delegates to the Sanitary Conference at Washington, and Dr. Covernton and Dr. Oldright to the British Association for the Advancement of Science, and the Canadian Sanitary Association at Montreal. The chairman will appoint a deputation, including himself, to the meeting of the American Public Health Association at St. Louis in October.

THE NEW BRUNSWICK MEDICAL SOCIETY.

The fourth annual meeting of the New Brunswick Medical Society was held in St. John, on the 17th and 18th of July. The attendance was large, there being fully forty members present. Hon. Dr. Vail, the president, occupied the chair. Dr. Musgrove, in the absence of Dr. Duncan, was appointed secretary *pro tem*.

The president made a brief address, expressing his pleasure at seeing so many members present, and describing the objects for which the society was formed and the advantages of belonging to it.

A communication was read from the W. C. T. U. referring to the increase of intemperance, caused to a certain degree by the administration of alcoholic stimulants by physicians, and calling upon the society to unite with them in suppressing intemperance. The communication was filed.

Dr. F. A. Nevers, the treasurer, reported that after paying the bills there remained on hand \$87.05.

The committee appointed to consider the feasibility of publishing a *Journal* reported in favor of the scheme, the publication to be entitled, *Medical and Surgical Journal* of the N. B. Medical Society. Messrs. J. & A. McMillan's offer to publish the work quarterly, 200 copies, twenty-four pages, without charge, on consideration that they receive the benefit of all advertising, was recommended for acceptance. The vote on its adoption stood 19 to 15. Drs. J. D. White, S. Z. Earle and J. T.

Steeves were appointed a committee to superintend the publication of the journal, and Dr. L. C. Allison was appointed editor.

The following officers of the society were elected: President, Dr. Thomas Walker; 1st Vice-President, Dr. E. M. Patterson; 2nd Vice-President, Dr. George Taylor; Secretary, Dr. T. W. Musgrove; Treasurer, Dr. D. E. Berryman; Cor-Secretary, Dr. W. F. Coleman; Trustees, Drs. Coleman, D. E. Berryman, Daniel; Council, Drs. Steeves, Earle, Vail, Moore, Christie.

Dr. Grant, of Ottawa, who was present, was invited to a seat on the platform, and addressed the society. He alluded to the energy, activity and ability displayed by the profession in New Brunswick, and was pleased to see so large an attendance. He also referred, among other things, to the excellent summer resorts in this part of the Dominion, and concluded by wishing the society many years of success.

In the evening there was a very pleasant conversation, at which a large number of ladies were present. Dr. Vail presided. A paper on Sanitary Science was read by Dr. Bayard. Music and short addresses by some of the medical gentlemen present, enlivened the proceedings. Refreshments were served during the evening.

SECOND DAY.

The society met at 10 a.m., Dr. Walker in the chair.

After routine, Dr. Gray read an excellent paper on "Uterine Fibroids," in which he gave a number of cases in his own experience. An interesting discussion followed.

Dr. Moore then read a paper on the treatment of "Hydrocele" by iodine and carbolic acid.

Dr. S. Z. Earle thought that these remedies would not effect a permanent cure. He related a case where the disease had returned after twenty-two years.

Dr. Harrison agreed with Dr. Earle. A similar instance had come under his notice.

Dr. Frank Nevers related a case in which he had used iodine, U. S. P. At first he did not think that his patient would rally, but subsequently he came round all right. In future he would be inclined to use carbolic acid.

Dr. McFarland read an interesting paper on "Conservative Surgery in Compound Fractures," and described the mode of treatment he adopted. One of his patients, whose leg had been badly mangled, was shown, and the limb examined.

Dr. Moore and others expressed satisfaction with the paper and hoped that it would lead medical men to be more careful in dealing with fractures.

Dr. James Christie said there were cases which terminate well, and there were other cases in which the patient dies. It was often a serious question,

whether we should amputate or not. In the present case a good constitution had largely been the cause of the patient's recovery.

Dr. Nevers related a case in which the patient had died by endeavoring to save her limb.

Dr. Coleman stated that the mortality in amputation of the thigh was 63 per cent.

Dr. Coleman then read a carefully prepared paper on "Some Points in the Diagnosis and Treatment of Diseases of the Eye." In the discussion which followed, the paper was warmly commended, and regret was expressed at the rumor that Dr. Coleman intended to leave St. John.

Dr. James Christie read a paper on "Amputation after Recent Injury," citing a case or two in support of his contentions.

At the afternoon meeting Dr. Musgrove read a paper on "The Proper Use of Alcohol as a Medicine," taking strong ground against its use, except in the way arsenic, opium, or any other poison is used. In the discussion which followed, the usual view prevailed, that competent medical men were the best judges of when and how to prescribe alcohol. The medical profession is opposed to the use of alcohol except in case of absolute necessity.

Last, but not least, was an admirable paper on "The Germ Theory in Disease," by Dr. J. P. McInerney, of Portland. Drs. Barker, Coleman and Grant spoke in high terms of the paper.

The next annual meeting of the society will be held in Fredericton, and Drs. Brown, Currie, Coburn and Barker were appointed to make arrangements.

HURON MEDICAL ASSOCIATION.

The regular meeting of the Huron Medical Association was held in Clinton on the 8th July, Dr. Williams, president, in the chair.

Dr. Hyndman, of Exeter, presented a case of hemoptysis, recurring since the 7th May, quite frequently. The patient last fall had an attack of bronchitis from which he apparently recovered. On careful examination the normal respiratory murmur was heard, except at one point about two inches in diameter and about the same distance below the left clavicle. His general appearance is one of fairly good health. There can, however, be little doubt that he has incipient phthisis.

Dr. Elliott presented a boy four years of age, who had been attacked with inflammation of the left arm below the shoulder, resulting in an abscess. Another soon formed at the joint, from which a quantity of pus was evacuated. The head of the scapula was found carious and the entire epiphysis removed at different times. The result was recovery with partial ankylosis. A little mobility of the joint existed which would likely increase.

Dr. Campbell, of Seaforth, reported a case of Pott's curvature of the spine, in a lady of 59 years, in which entire recovery took place after seven plaster of Paris jackets had been used. He also reported a case of pleuro-pneumonia ending in empyema. Six pints of healthy pus were taken by aspiration, and fourteen days after eight pints of very fetid pus were removed by free incision, and the cavity washed out three or four times a day with carbolic lotion.

Dr. Worthington presented a case of rodent ulcer, situated at the outer angle of the left lower eyelid. The treatment advised was scraping with Volkman's spoon and cauterizing with chloride of zinc solution. He also presented a case of congenital defect of the spinal medulla, and probably of the left frontal lobe of the brain. The patient is six years of age, and cannot walk, but is making some effort to do so, and also to talk. When an infant he had no control over the motions of his head whatever. When attempting to walk he is bent very much forward and both arms extended. There is a want of co-ordination which in time seems likely to be overcome. He has perfect control of his passages.

Drs. Smith and Nichol are to prepare papers for the next meeting.

BATHURST AND RIDEAU MEDICAL ASSOCIATION.

The eleventh annual meeting of the Bathurst and Rideau Medical Association was held at Carleton Place, on the 9th of July. There was a large attendance of members present, Dr. Cranston, President, in the chair. The Secretary's minutes and Treasurer's report were read and adopted. The latter announced that as there were sufficient funds on hand no levy would be made this year upon the members.

The President, in his annual address, alluded to the work done in the Medical Council, referring particularly to the proposed changes in the Medical Act. A discussion followed, in which many took part; the increase of the annual fee was objected to, especially the payment of a life fee which, it was contended, would only encourage extravagance in the Council, and when the fund was exhausted, the practicing physicians would again have to contribute to support the Council.

Dr. R. H. Preston exhibited a case of disease of the ankle joint. The trouble was of several months duration, pain was now very severe, swelling slight, tenderness not very marked, movements of foot were not difficult. All usual remedies, both internal and external, had been tried; he proposed to drill for pus, suspecting an interosseous abscess of the tibia. Drs. Grant, Horsey & McEwan concurred in his views.

Dr. Grant, jr., read a paper on "The Pathology

of Tubercle," exhibiting several slides of tuberculous and healthy tissue of various organs.

The Secretary read a paper from Dr. Malloch, of University College Hospital, London, reporting a case of "Hydatid Disease of the Liver," detailing operation and post mortem appearances.

The following officers were elected for the ensuing year: President, Dr. Cranston; 1st Vice-President, Dr. Preston, M.P.P.; 2nd Vice-President, Dr. Horsey; Treasurer, Dr. Hill; Secretary, Dr. Small.

The meeting then adjourned, to meet in Ottawa in January, 1885.

NOVA SCOTIA MEDICAL SOCIETY.

The annual meeting of the above named society was held in North Sydney, C.B., on the 9th and 10th of July, under the presidency of Dr. Somers, of Halifax. There was a good attendance of members. After routine, the President delivered an able and instructive address. The reports of the Standing Committees were then presented. The report on Medicine was prepared by Dr. Moore, of Kentville, and in the discussion that followed, the communicability of phthisis was chiefly taken up. It was decided to issue cards to the profession that a record may be had of all cases of this kind during the year.

The report on Surgery was presented by Dr. Stewart, in which he raised the question of anti-septic treatment of wounds, etc., upon which the President had also touched in his address. The report elicited considerable discussion.

In the afternoon, Dr. McGillvray presented the report on "Therapeutics," giving a succinct classification of recent popular remedies, showing that 97 in a list of nearly 300 had been more or less successfully adopted, while 190 had been rejected as useless. Dr. Angus, of Oxford, also reported for the same committee. The report on "Obstetrics" was presented by Dr. Page, in which he criticised the systems adopted by certain schools of practitioners.

The following gentlemen were elected members of the Provincial Medical Board under the new Medical Act: Drs. Somers, Wickwire, and J. F. Black, Halifax; Johnson, Sydney Mines; McIntosh, Antigonish; and Perrin, Yarmouth.

Dr. Tobin, of Halifax, read a paper on "The Modern Operation for Cataract Extraction," which was well received.

In the evening session a paper was read on "Medical Education in Nova Scotia" by Dr. Reid, Superintendent of the Insane Asylum.

On Thursday morning, Dr. J. W. McDonald read a paper on "Sanitation in regard to Diphtheria." In 1880 no less than 2,000 deaths occurred from this disease in Nova Scotia, but last year so great was the advance of the people in

sanitary knowledge, the death rate fell below 500. Dr. McDonald contended that the prevalence of diphtheria was entirely owing to the lack of sanitation. Quite an animated discussion followed in regard to the infectiousness of diphtheria. Dr. McKay followed with a paper on "Sanitary Legislation." He advocated the enforcement of our present sanitary laws, the establishment of a Department of Public Health in the Cabinet, and the appointment of an Inspector of Health for each County.

The following officers were elected for the ensuing year: President, Dr. H. B. McPherson; 1st Vice-President, Dr. John Stewart; 2nd Vice-President, Dr. T. R. Almon; and Secretary, Dr. J. W. McDonald. Dr. W. McK. McLeod was placed on the Standing Committee on Medicine; Dr. Lewis Johnston on that of Surgery, and Dr. Wm. McKay on that of Obstetrics.

In the afternoon the visiting gentlemen enjoyed an excursion on the harbor, as the guests of the C. B. Medical Association.

The society met again in the evening. The question of the union of the associations of the Maritime Provinces came up, but its consideration was deferred. Dr. Stewart gave notice of his intention to move next year in regard to the matter of physical education in the public schools.

After the usual votes of thanks, the society adjourned to meet next year in Halifax. Much of the success of the present meeting was due to Dr. McPherson, upon whom devolved the local arrangements.

MICHIGAN STATE BOARD OF HEALTH.

Reported for the CANADA LANCET.

The regular quarterly meeting of the Board was held in Lansing, July 8, 1884.

The Secretary presented a report on four outbreaks of cheese-poisoning in Michigan, during May and June. All persons who ate of the cheese were taken sick, (in all about one hundred and sixty-four persons), with the same symptoms, i. e., pain and burning sensation in the stomach, intense vomiting and purging, feeble pulse, cold extremities, and tendency to collapse. All finally recovered. Specimens of the cheese were analyzed. Everything about the factory appeared to be scrupulously clean, and nothing in vats, cans, or surroundings offered any explanation of the cause of the poisoning. Analysis showed no arsenic, copper, lead, iron, or other mineral poisons. When the cheese was cut or broken, a whitish liquid oozed into the pores, and in the liquid microscopic organisms were detected. For more than one hundred years the attention of the scientific world has been drawn to the subject of cheese poisoning by repeated outbreaks from time to time. It has been variously ascribed to diseased milk, decomposition

and the development of certain fatty acids, etc.; but it is not yet known what makes the cheese poison. The manufacturer said the cheese which produced the ill-results was all made between April 26 and May 26, 1884. It was made in the same manner and with the same care as other lots which had given no cause of complaint. Good cheese is only very slightly acid, and slowly reddens blue litmus paper. The poisonous cheese was intensely acid, instantly reddening blue litmus, when the paper was applied to the freshly cut surface. This test for poisonous cheese appears to be practicable. The blue litmus paper could be applied by any grocer to each freshly-cut cheese.

The Secretary reported an outbreak of small-pox in Ross Lake, introduced by a German immigrant. He said this outbreak was another illustration of how Michigan and the North-west suffer from the lack of a careful immigrant inspection service, such as was planned by the National Board of Health, and for a time carried on, but discontinued for want of an appropriation.

Owing to the spread of Asiatic cholera in Europe, and the liability of its introduction into this country at any time, it was decided to issue a circular to local Boards of Health on the prevention and restriction of cholera.

Other circulars on infectious diseases were ordered to be printed and distributed. A report of the work of the Secretary's office concluded the work of the Board.

Selected Articles.

CLINIC, BY ROBERTS BARTHOLOW, M. D.

CHRONIC ILEO-COLITIS.—The first case to be exhibited this morning, the child before you, was shown you some time ago, suffering with chronic ileo-colitis. The disease had been extremely persistent and severe, but under a properly regulated diet and the use of tincture of iodine and carbolic acid, the so-called carbolate of iodine—a half a drop of each being taken three times a day—there has been rapid improvement, and now the symptoms have disappeared, notwithstanding that the instructions in regard to the regulation of the diet have been imperfectly obeyed. You will remember that I insisted upon a change in the diet as of the first importance in the treatment of this case.

I hope that you will observe the character of the cough which the child has. It has frequently occurred ever since the existence of the ileo-colitis. Every time the child takes cold it has this hard, ringing cough which you now hear, and which is termed a "croupy cough." I have on several occasions insisted that this phrase is a misnomer. It is called croupy simply because it has the loud, ringing, metallic character which is as-

sociated with the cough of spasmodic croup. This is not the true croupy cough. The cough of exudative laryngitis is husky in addition to being ringing and metallic. The cough which this child presents is significant of laryngismus stridulus; that is, an affection of the larynx in which the muscles are thrown into a state of spasm. A child who during the day has been exposed to the cold, or who in the evening has eaten heartily of indigestible food, wakes up in the night with an attack of so-called croup. This is really an example of laryngismus stridulus, or spasm of the muscles of the larynx. In the case I have supposed there are two factors: the child takes cold, or it has an irritation of the gastro-intestinal mucous membrane. We can here apply with great certainty our physiological knowledge. The mechanism is very obvious. The pneumogastric nerve which supplies the mucous membrane of the fauces, and the gastro-intestinal mucous membrane in part, also has branches going to the larynx. This nerve is both motor and sensory in function. All the muscles of the larynx, with the exception of the crico-thyroid, are supplied by the inferior laryngeal nerve, while the superior laryngeal nerve is distributed to the mucous membrane and the crico-thyroid muscle. Now we have the terms of the problem. Irritation of the peripheral distribution of the pneumogastric nerve is referred to its motor branches, and the muscles of the larynx are thrown into a state of spasm. It would be a great mistake to confound this condition with true croup.

LARYNGISMUS STRIDULUS.—As laryngismus stridulus is merely a reflex spasm of the muscles of the larynx, those remedies which relieve spasm are the appropriate ones to use. In the present case we can prescribe a remedy which has a twofold effect; a remedy which benefits the intestinal inflammation, by acting through the nervous system, and which is also very effective in relieving the muscular spasm. This remedy, the bromide of potassium, will allay spasm of the muscles of the larynx, and it will also relieve certain kinds of irritation of the gastro-intestinal mucous membrane. In that disease commonly known as summer complaint bromide of potassium is one of our most efficient remedies. Why? Because it acts on the vascular supply of the mucous membrane, through the nervous apparatus, the semi-lunar ganglion and solar plexus. We have in this drug a remedy which fulfils all the indications of the present case. I direct five grains of bromide of potassium to be taken every three hours until the symptoms subside. The injunctions in regard to the diet must be repeated. When I last saw the child I carefully indicted the food which should be used. I now learn that the child has been given bread in considerable quantity, with the idea that bread, being the staff of life, can do no harm, and is always in place. In such cases as this bread is

always out of place. It is unsuitable; because it is an eminently fermentable substance, and in the process of fermentation acids are produced which have an irritating effect on the inflamed mucous membrane.

CHLOROFORM IN TIC DOULEUREUX.—Here is another case which you have seen before, and I can now show you the result of treatment. It is a case of tic dououreux, *i. e.*, neuralgia of the superior maxillary branch or division of the fifth nerve. You will remember that I pointed out the various features of this case, indicated the painful points, and referred to the remedies most appropriate in its treatment, and I prescribed a remedy which has been found singularly efficient. There is no fact in therapeutics more striking than the curative results of a few drops of chloroform injected in the neighborhood of this division of the nerve, when it is the seat of neuralgia. In my experience the superior maxillary division of the fifth nerve is, above all the divisions of the nerve, most apt to be affected with neuralgia. Fortunately, it is this division of the nerve which is most easily acted upon.

Given a case of tic dououreux involving this nerve, how shall it be relieved? Simply lift the corner of the lip and insert the needle at the junction of the mucous membrane of the lip and that of the cavity of the mouth, and pass it up until its extremity comes in the neighborhood of the nerve, and inject from five to fifteen drops of chloroform or ether. As a rule, chloroform is less painful and more efficient than ether. In this case the pain at once subsided, and in the majority of cases the result, if not permanent, lasts for a considerable length of time. I have a patient in Boston, who comes to me twice a year to have this injection practised. In his case the neuralgia is probably due to intra-cranial disease. This measure has accomplished that which nothing else has done. The relief which he obtains is complete, and lasts never less than six months.

PARALYSIS FROM ENLARGED LYMPHATIC GLANDS.—This case has also been before you, and I am the more desirous of presenting it to you as there were some rather confused points in regard to the diagnosis. In this patient the parotid gland and the lymphatic glands of the right side of the neck were greatly enlarged. This swelling of the glands was followed by an attack of hemiplegia. The mechanism which I maintained to be explanatory of this is the following: This mass of enlarged glands presses upon the cervical sympathetic and affects the intra-cranial blood supply. You will probably at once ask, "How is it that the paralysis involves the right side, for the enlarged glands are on the right side, and we know that the superior cervical ganglia controls the circulation of the same side of the brain?" We learn from the experiments of Bernard, which have frequently

been repeated, that when the cervical sympathetic is divided the corresponding side of the face and head becomes flushed, owing to the paralysis of the vessels. Suppose, however, that the nerve is merely irritated the unstriped muscles supplied by that nerve are thrown into a state of spasm, and this causes a diminution in the blood supply, the degree of which depends on the amount of spasm. In other words, irritation of the superior sympathetic produces anæmia of the brain. This does not explain the occurrence of the paralysis on the right side. It is a peculiarity of some cases that the impression is crossed. Why this should be has never been adequately explained. It is, however, a practical fact that the paralysis sometimes occurs on the same side as the lesion, and not on the opposite side.

The patient has been improving under the treatment, which consisted in the administration of one-half grain of sulphate of iron with $\frac{1}{160}$ of a grain of sulphate of strychnia three times a day. As you can see he has great difficulty in combining muscular movements. Looking at the face you observe that on the right side, the labio-nasal fold which passes from the corner of the mouth to the corner of the nose, is much less distinct than it is on the left side. This is always an important point. A very positive evidence of paresis of the seventh nerve is often afforded by that sign.

LUMBAGO.—A short time ago I presented several cases of lumbago, and dwelt on the differential diagnosis and treatment. Some of the cases were strictly of a rheumatic nature, while others were more of a neuralgic character. I enlarged upon the essential differences between these two forms of the disease, and pointed out how certain states of the system had much to do with the results of treatment.

In this case we had to deal with a rheumatic lumbago, and we put him on the use of salicylic acid. The pain has disappeared and the patient is nearly or altogether well. In those cases which are distinctly rheumatic, there is no question as to the efficiency of this remedy. I at the same time advised the external use of oil of wintergreen, which has been found of service in muscular rheumatism so situated as to be reached by topical applications. The result here has been eminently satisfactory.

INTERMITTENT FEVER.—This little girl has had attacks which the mother supposed to be sick headache. They have occurred periodically, but of late have been increasing in frequency. On inquiry we learn that the attacks began with chilly sensations and often with a decided chill. This was followed by violent fever and headache, and terminated in sweating. With the commencement of chilly sensations there appeared nausea, violent vomiting and distress of the stomach.

Looking at the phenomena presented by this

history, there is no difficulty in making the diagnosis. The child lives in a malarial part of the city. The attacks begin with a chill, followed by high fever, and terminate in sweating. The frequent recurrences of the seizures, and their persistence, indicates the existence of changes in the condition of the spleen and liver. In many examples of chronic malarial toxæmia the spleen is enlarged, but sometimes it is smaller than normal; in other words, in the most chronic cases the spleen is the seat of a chronic splenitis. The liver is also changed, being affected with pigment deposits and disorders of its circulation—the nutmeg liver. The paroxysms will recur as long as these modifications in the condition of the liver and spleen are allowed to continue.

The question which we have to consider is, how best to arrest the attacks. As the gastric disturbance is so great, attention to the diet will be necessary. In order to prevent the occurrence of the paroxysm, quinine must be administered, in anticipation of the seizure. We must do something more than this. The condition of the liver and spleen must be taken into consideration, for although there is no enlargement of the area of dullness proper to these organs, I have no doubt that they are the seat of the changes which characterize chronic malarial toxæmia. The spleen in these cases is not necessarily enlarged, and may, indeed, as already stated, be smaller than normal. The organ may be in the condition known to practical pathologists as the "fleshy spleen." This is a chronic alteration in which the trabeculæ are very much increased in amount, and the splenic pulp proportionately diminished. There is hypertrophy and hyperplasia of the connective tissue elements, and hence its fleshy appearance.

There are two remedies to influence the liver and spleen, which are especially valuable. The one is aqueous extract of ergot and the other is an iodide, especially iodide of ammonium. There is also a condition of anæmia for which remedies of the chalybeate group are indicated. The most appropriate one in the present instance is the arseniate of iron. The best results will be accomplished by giving quinine, to prevent the recurrent attacks, and the use of a pill, containing the following:—

R.	Extracti ergotæ,	℥ j	
	Ferri arseniatis,	gr. ss	
	Ammonii iodidi,	℥ j.	M.
	Ft. pil. No. xx.		

SIG.—Two pills three times a day.

This prescription should be very persistently used. Under this plan of treatment, we will see the paroxysms subside and the marked improvement take place in the general state.

EXOPHTHALMIC GOITRE.—Before us is a case of exophthalmic goitre. One of the symptoms is

very manifest. You see the marked protrusions of the eyeballs. Let me first give the quaternary of symptoms in which this curious malady consists : first, protrusion of the eyes ; second, enlargement and pulsation of the vessels of the neck ; third, enlargement of the thyroid gland, and fourth, rapid action of the heart. Two of the symptoms give the disease its name—the exophthalmos and the enlarged thyroid.

Are all the symptoms present in this case ? You see the condition of the eyes. I direct the patient to look downward ; the eyelid does not follow the movements of the ball, and a considerable amount of the sclerotic is exposed. The cause of the protrusion has been much disputed. It has been attributed to œdematous swelling of the tissues back of the eye, and also to the action of the unstriated muscle of the orbital membrane. The latter is probably the chief cause.

Looking at the thyroid, it is found that although it is not much enlarged, the change is characteristic. It is the right side of the gland which is involved ; the left side does not exhibit any enlargement. When only one side is affected, the rule is that it is the right side. The left side may subsequently be involved. In typical cases, the vessels of the thyroid also become enlarged, so that the gland pulsates like an aneurism and is often confounded with aneurism. The enlargement also presents the aneurismal whirr and thrill. This enlargement may be either temporary or permanent. At first the enlargement is merely due to the vessels ; afterwards to the hyperplasia of the gland elements. In consequence of the lesion of the sympathetic, which is the seat of the trouble, the vessels dilate. The vessels of the neck in typical cases also become enlarged. We also find in this patient that the heart is affected. In typical cases where there is no lesion of the heart, the action of the heart is simply increased, the number of pulsations being increased, and the force of the pulsation much greater than normal. In old subjects, changes in the structure of the heart are apt to occur. In the present instance, when I apply a stethoscope over the heart, and especially over the mitral area, I hear a double murmur. This is not merely anæmic, but it is due to lesion of the valves. There are various changes which may take place in the heart, but no one of them can invariably be referred to this malady. As I have said, the heart is not necessarily the seat of any lesion in this disease, the only change being the increased number and the force of the pulsations. This might take place in one of two ways, either from irritation of the accelerator, or paralysis of the inhibitory apparatus. In this disease the lesion is in the accelerator nerves which arise from the sympathetic, and not in the pneumogastric nerve. Such is the mechanism and such the pathology of this affection.

This being the nature of the case, what is the appropriate treatment ? I have effected cures in several cases by persistent galvanization of the cervical sympathetic. This is done by placing one electrode in the fossa behind the angle of the jaw, and the other in the epigastrium. The continuous current should be passed for five, ten, or fifteen minutes. This at once diminishes the pulsation, and the protrusion of the eye is lessened. Of course, one application will not affect a cure ; but I have no hesitation in asserting that in all uncomplicated cases, occurring in young subjects, a cure may be effected by the persistent use of the galvanic current.

In addition to this, remedies which modify the activity of the sympathetic system may be administered by the mouth. Digitalis has been much used, and has sometimes been of service. Ergot has also done good in many of these cases.

INSTRUMENT FOR OPENING PELVIC ABSCESES.

In the *Pacific Med. Journal*, Clinton Cushing, M.D., Professor of Gynecology Cooper Medical College, describes a new instrument for opening pelvic abscesses through the roof of the vagina. The most frequent site for a pelvic abscess is either in Douglass' pouch behind the uterus or in the connective tissue of one or both of the broad ligaments on either side of the uterus. It may also occur in the connective tissue between the uterus and bladder, but this is quite rare. It may open into the vagina, the rectum, through the abdominal wall, into the bladder, or into the peritoneum ; of the last mentioned, out of nineteen cases of pelvic abscess reported by Savage, of London, three terminated fatally in this way, and out of three cases opening into the rectum two proved fatal. The most favorable point for the escape of the pus is through the vagina. Between the uterus and bladder, there are no arteries of a size to make them of importance from a surgical point of view ; but on either side the cervix, just above the junction of the vagina with the uterine neck, very important structures exist—no less important than the ureters and the uterine arteries. The uterine arteries which are as large as the radial, branch off the internal iliac on the sides of the pelvis and pass inward to the sides of the uterus just beneath the base of the broad ligaments and within a half inch of the roof of the vagina. The ureters pass over the brim of the pelvis beneath the pelvic peritoneum and run forward on either side the cervix to their position between the bladder and vagina. They cross the uterine artery about three-quarters of an inch laterally from the cervix, and both the ureter and artery are directly in the way if an at-

tempt is made to evacuate pus in broad ligament through the vaginal roof. The instrument—of which I herewith present a wood-cut one-third the size of the original—consists of two blades, which when closed form a trocar, and when introduced into an abscess direct, or along the side of an aspirator needle, the handles can be closed and the extremities separated so as to act as a dilator, and thus tear the connecting tissue sufficiently to furnish the most ample room for the escape of pus and the introduction of a drainage tube.



The manner of using it is simple. After making a digital examination and locating by the sense of touch the point in the vagina that you have determined to explore, turn the woman on her side in the Sims position, on a table before the window where the light is good. Introduce a Sims speculum and give it to an assistant to hold, and then seize the cervix with a small vulsellum to steady it. If the induration where the suspected pus is supposed to be presents no sense of fluctuation to the finger, pass a slender aspirator needle into the mass by means of a pair of strong dressing forceps and determine whether pus is present; if so, now make a slight incision alongside the needle and then introduce the trocar-pointed dilator by the side of the aspirator needle directly into the cavity of the abscess and close the handles before withdrawing it, leaving a large patulous opening into which the finger can be introduced, and of a character that does not tend to heal readily, admitting also of the easy introduction of a drainage tube. If fluctuation can be made out, the use of the aspirator is unnecessary. The advantage of this instrument over a knife is, that the danger of injuring the ureter or artery is reduced to a minimum; and the advantage over a trocar, is that of being able to make a large and free opening before withdrawing it, and with no additional risk. Doubtless the possession of this instrument with a knowledge of its use would give many men the courage to open and cure pelvic abscesses, that otherwise would allow them to go on to a bad ending. One of the difficulties attending the treatment of pelvic abscesses by openings through the vaginal roof is the inability to prevent the closure of the opening before the pus cavity has become entirely closed and healed, thus leading to a re-accumulation of matter. In order to meet this

indication, I have devised a self-retaining drainage tube that has proved most satisfactory in my hands. The tube is made by taking a piece of rubber tubing of pure gum, the size of a lead pencil, and cutting off a section three-quarters of an inch long, in which an opening is made at its centre, at one side, equal to the diameter of the piece of tubing. This is now fastened transversely across the end of the longer piece of tubing with silver wire. It is easily introduced by means of a pair of long-handled dressing forceps, and when in place will be retained without difficulty, unless considerable force is made to withdraw it. Through this tube the cavity of the abscess can be easily washed out if needed, and it can be left in as long as any purulent matter escapes.

TAIT'S OVARIOTOMIES.

A correspondent in the *St. Louis Courier of Medicine* gives the following: The other day I asked Dr. Savage to what he attributed his and Mr. Tait's success—for they are very similar in their methods, and have much the same results—and he replied: "It can all be summed up in three words, 1st, cleanliness; 2nd, dryness, and 3rd, dexterity." To which I would add "carefulness."

The first, "cleanliness," brings up the question of antiseptics, which can be disposed of in a word, neither of them uses them. I may have something to say on this subject in a future letter, but, from what I have already seen, I must say that my confidence in Listerism has been very much shaken. Tait uses nothing but pure water, but Dr. Savage does use a little carbolic acid in the water in which his instruments are placed. The instruments and sponges are, of course, scrupulously cleaned, and plenty of water is used from beginning to end, but that is all the antiseptic that is used. There is no oiled silk or anything of the kind placed over the abdomen, but the parts are sponged thoroughly clean before operating.

There are only four persons who take part in the operation, the operator, his assistant, and two nurses to manage the sponges. The nurses have to redress before coming from the other patients, and in fact everything is done that can possibly be done to insure perfect cleanliness. If there are any visitors present, they are required to sign a certificate to the effect that they have not attended any post mortem examinations or contagious diseases for six days.

Before the peritoneum is opened, the external bleeding is arrested with Koeberle's scissor-shaped artery forceps, which are left on until it is necessary to complete the operation, when, as a general thing, all the bleeding is stopped. Just as soon as the peritoneum is opened, sponges are inserted

ad libitum. I have seen as many as twenty sponges in the abdominal cavity at one time. Before closing the incision, dry sponges are put in and taken out until they finally come out dry and clean, so that Baker Brown's old rule, "don't sponge the peritoneum," has been replaced with the opposite, "sponge until perfectly dry."

Mr. Tait is renowned for his short incisions. As a rule he seldom makes an incision longer than an inch and a half in simple ovariectomies, or the removal of the appendages. With this small opening, barely large enough to admit his two fingers, he diagnoses the case, and generally completes the operation. From what I have seen, and judging from a discussion that has just taken place in the *Lancet*, I am led to believe that no one ever attempts to perform the operation with as small an opening as Lawson Tait. He is remarkably skillful with his fingers, not only in abdominal section, but in every other operation I have seen him perform.

Carefulness in little things has much to do with success. In every operation there are the same number of artery forceps (12), the same number of sponges (either 12 or 20.) When the operation is about completed, and the sutures ready to be tied, the nurses have to count the sponges, etc. This, of course, is absolutely necessary, for it is a very easy matter to leave a sponge in. Several times I have seen the operator search the abdominal cavity for some time before a sponge could be found, that was known to be there only from counting them. The anæsthetic used is bichloride of methylene.

His method of treating the pedicle is the intraperitoneal, after ligating with silk. He uses a peculiar double knot for tying the pedicle, which, for want of a better name, I would call the Tait knot. The advantages of this knot are that while the whole is compressed into one surface, it ties the pedicle in two halves, and at the same time these halves are equally well compressed, so that very great, constricting force can be employed. To tie with this knot a long handled needle is threaded with the silk required and pushed through the centre of the pedicle. The needle is then withdrawn, and a loop left on the opposite side of the pedicle. Then the loop is drawn over the tumor or ovary, and one of the free ends drawn through it, so that one end is above and the other under the retracted loop. Both ends being seized they are drawn through the pedicle, till complete constriction is made. A simple hitch is then made and tightened, as in an ordinary ligature. The pedicle is then cut about a third of an inch from the ligature.

The intraperitoneal method of disposing of the pedicle was a long while in being adopted, but it has been the means of lessening the mortality at least fifteen per cent. There are times, however,

when the clamp must still be used. But in all the operations I have seen, I have only seen the clamp used five times—four by Mr. Tait and once by Dr. Savage—the latter a Porro's operation, and the removal of a six month's child.

During the ten weeks I have been here, Mr. Tait has operated sixty-five times, with only one death. The fatal case was a cancer case, and the operation was a *dernier ressort*; the woman died in twelve hours. Thus, throwing out this case, which really ought to be thrown out, we have sixty-four consecutive cases in ten weeks without a death. When we think what was the rate of mortality only a few years ago, when we expected at least twenty out of every hundred to die, we may well rejoice at the results of the present methods.

RETAINED PLACENTA.

Dr. T. Parvin in a paper read before the Philadelphia Co. Medical Society, thus discusses the management of retained placenta:—As long as the placenta is wholly attached, hemorrhage is impossible; the placenta is still a living structure and one with the uterus; to tear it loose, to directly detach it from the uterus, opens the way for perilous hemorrhage. Not only this, but such artificial detachment is usually incompe etc, is liable to injure the uterine tissue, and the operator's hand may be the bearer of septic germs, or these may pass in with the air admitted during the manipulation, and find a congenial soil for their development in fragments of placenta, or blood-clots that are retained in the uterus. Therefore, unless hemorrhage demands immediate interference, the obstetrician refrains from passing his hand into the uterine cavity for the removal of attached placenta; a completely adherent placenta is not so dangerous as the intra-uterine use of the hand for its detachment. I believe, then, that armed expectation is wise in the latter case, only endeavoring, by suitable compression of the uterus with the hand acting through the abdominal wall, to determine or assist that retraction of the organ which is nature's method of separating the placenta. After the detachment of the placenta—a fact which is best learned by feeling a part of the organ with the finger passed into the mouth of the womb—we may, by friction and compression of the uterus, if needed, evoke uterine contractions which will cause its expulsion. Those who believe that the placenta presents its fetal surface at the os uteri, urge the value of moderate and continuous traction upon the cord, thus assisting the moulding of the mass to the orifice through which it is to come. This conservative view as to the management of so-called retained placenta has been strongly presented by Siredey in his recent work upon puerperal diseases. The common expression, retention

of the placenta, means very different conditions, each requiring its appropriate treatment.

Dr. Parvin concludes with a study of a ruptured uterus. The uterus was ruptured in consequence of a shoulder presentation, a case which ended in death the eighth day after delivery. Yet, he said, I would fail in duty to my profession that has been so generous to me, if I did not make the case fully known. The patient was a well-formed multipara; she had been in labor nearly twelve hours when I first saw her, the left shoulder presenting. Ether was immediately given until she was thoroughly under its anesthetic effect; and then, without violence, nay, with great ease, I passed two fingers behind the right knee, brought the foot down, and turning and delivery were effected in a few minutes; the placenta followed almost immediately; the child, quite a large one, was dead. The patient came out from the anesthesia satisfactorily; her pulse was good; there was no complaint, no shock, no great hemorrhage. Yet that woman had a ruptured womb, the tear beginning at the os uteri on the right side, involving the cervix and the lower part of the body of the uterus, this condition being made known by the post-mortem. If it be thought I ought to have known this accident at the time of delivery, I can only say that like ignorance happened to Dubois, to Hervieux, to Tarnier, and others—the first revelation of the uterine rent being made at the post-mortem; these silent tears of the womb are, as Hervieux has suggested, probably more frequent than generally thought. No, my self-reproach is not in this, but in not having made myself, or by another, an examination during pregnancy, so that the abnormal presentation could have been corrected, if not then at least in early labor. But let this pass. The great practical lesson to be drawn from the accident is not only the importance of an early rectification of a mal-presentation, but also an appreciation of the danger of rupture of the uterus, and how this accident occurs. The drawing now shown gives the position occupied by the child, and also and especially gives the change in form and thickness of the two cavities of the uterus, which, as so admirably described by Bandl, are formed when nature is unable to overcome the obstacle to labor found in such case. The one cavity is formed by the body of the uterus, and its walls become thicker and stronger; the other by the cervix, and its walls grow thinner—become indeed so attenuated and weak that a very slight additional strain at some point; that strain may come from a uterine contraction, or solely from the introduction of the finger; and thus peril from action, peril from delay must be before the obstetrician's mind when called to a case of neglected shoulder presentation.

Of course had I seen this patient an hour or two earlier, the event might have been different. The pressure of the presenting part had been so severe that a slough of the vesico-vaginal wall oc-

curred, and the patient, had she recovered, would have required an operation for the resulting urinary fistula. I have thought that possibly the uterine rent was in part the result of a slough also; but be this as it may, there was not the slightest indication given at the post-mortem that any hemorrhage in the abdominal cavity had taken place.

THE EASY APPLICATION OF THE FORCEPS.—One of the chief minor objections to the use of the forceps is the fuss and trouble necessary to place the patient, already much exhausted and worried, in the orthodox position close to the edge of the bed, and, when so placed, patients frequently complain of feeling unsafe, and as if in danger of falling.

Let the patient lie in the ordinary position on her side, and at a reasonable distance from the edge of the bed, then let the upper blade be introduced as a lower blade, and then passed posteriorly round the head of the child into its proper position as the upper blade. When this is accomplished, the lower blade may be introduced in the usual manner, and the two handles locked. No force must be used, but the handle of the forceps manipulated as gently as that of a catheter when being introduced into the male bladder. I have applied the forceps in this manner more than twenty times in the last three years without any difficulty, and without causing any injury to the head or face of the child.

In teaching the use of the forceps, I think too little is said as to the direction in which the force should be applied after the head has reached the perineum, and when it is considered wise or justifiable to terminate the labor with the help of the forceps. I believe the force should be applied anteriorly, in a curved direction, terminating in a line almost parallel with the abdomen of the patient; in fact, in the same direction in which one might imagine that the woman herself would pull if attempting self-delivery with the forceps. Were more attention paid to this point, I am convinced that many perinæ which are now lacerated would escape uninjured.—Dr. Cribb, *Brit. Med. Journal*.

REMEDIES FOR GONORRHEA.—No 1. —R. Liq. ferri. subsulphatis, gtt.xv.; aquæ font q. s., ʒ iv. No. 2.—R. Hydrastin muriatis, ʒ j; glycerinæ puræ f. ʒ ss; aquæ font q. s. f. ʒ iv. Directions. —Wash out urethra well with warm water, then inject formula No. 1. Six hours after use No. 2 by injection. Four days is all I ask for cure. This treatment has never failed where I have given it.—*Therap. Gaz.*

THE sulpho-carbolate of sodium, in thirty-grain doses given after meals, is recommended in flatulent dyspepsia. Also in ten-grain doses for nausea and vomiting, particularly in pregnancy.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science
Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMillan, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHER, 23 Rue Richer, Paris.

TORONTO, SEPTEMBER, 1884.

The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

THE SPREAD OF CHOLERA.

Considerable anxiety is felt by the public in regard to the probable appearance of cholera on this side the Atlantic. It is impossible to say how soon, or when it may reach our sea-coast, for in these days of rapid railway and steam communication the germs may be carried to very distant parts in an almost incredibly short space of time. But whatever opinions may be entertained regarding the spread of cholera, the duty of the civic authorities, boards of health and the general public is clear. It is not enough to spend a few hundred dollars in cleaning up the filth in back lanes and alleys, the most thorough inspection and disinfection must be enforced. If proper and timely precautions are taken there need be no dread of cholera. Its outbreak in Toulon was the result of gross carelessness, and its continued spread the result of the *most disgraceful unsanitary conditions*. Although the violence of the epidemic has considerably abated, the area is very much enlarged, it having spread into the interior of France and Italy. At last accounts an outbreak in Algiers was feared. Koch has given the following instructions regarding the methods of preventing the spread of cholera: 1. Avoid contact with cholera patients or clothes worn by them; 2. practise temperance in eating and drinking; 3. avoid food that comes from an infected locality—cook it well; 4. see that the drinking water is *pure*—boil it; 5. avoid large gatherings; 6. disinfect choleraic evac-

uations with carbolic acid; 7. vacate apartments of cholera patients six days; 8. wash the hands with soap and water and carbolic acid if they have been in contact with cholera patients or their clothing; 9. disinfect linen before sending to the laundry; 10. disinfect all clothing of patients before transportation. The best disinfectants for cholera are carbolic acid, corrosive sublimate, and the zinc and copper salts.

A singular circumstance is mentioned in connection with the cholera in Marseilles, viz., that the swallows migrated at the outbreak of the pestilence and have not yet returned.

There are no specifics in the treatment. As most cases are preceded by a painless diarrhoea, it is well to adopt early treatment, so as to check it in the outset. Hypodermic injections of morphine and the internal use of opium, aromatics and astringents will be found most serviceable. Stimulants should be used with great caution. Horner's mixture, which has been recommended by Hartshorne and Bartholow in the *rice water* stage, is as reliable as any of the numerous so-called specifics:

R—Chloroform,

Tr. opii,

Spts. camph.,

Spts. am. aromat.,

Creasot.,

Ol. cinnamom.,

Spts. vin. gall.,

aa 3iss.

gtt. iij.

gtt. viij.

3ij.—M.

Sig.—Dissolve a teaspoonful in a wineglassful of ice-water, and give two teaspoonfuls every *five* minutes. The following is the treatment adopted at Toulon and Marseilles:—In the first stage, twenty drops of laudanum are given with three grammes of ether, and ice in the mouth, to stop the vomiting. In the second stage, from ten to fifteen grammes of acetate of ammonia, the same quantity of alcohol, and injections of morphia, are given. If the breathing is embarrassed, oxygen is inhaled and the limbs rubbed with turpentine; and the *Medical Record* gravely adds, "the third stage is the coffin."

SURGERY OF THE URINARY ORGANS.

Late English journals bring us a report of the first of a series of lectures to be delivered by Sir Henry Thompson on the surgery of the urinary organs. Perhaps no man, living or dead, was ever better qualified to speak on this branch of surgery.

With rare natural and acquired gifts he combines a varied experience, in his chosen specialty, extending over a third of a century. The skill and experience which have made his name famous in this branch of surgery, he now proposes to make an open book for the benefit of suffering humanity. Thus it ever is in the higher walks of medical and surgical knowledge. The light is not hidden under a bushel to serve a selfish purpose, but is rather so placed that all who look may see.

Sir Henry, in his preliminary remarks, stated, that he became a specialist not from deliberate choice but by the merest accident. When about entering on the practice of his profession the Council of the College of Surgeons offered for competition as the subject of a Jacksonian prize, the "Pathology and treatment of Stricture of the Urethra." To the accident of having obtained this award, and not long after another Jacksonian prize for an essay on the prostate, he attributes the shaping of a career which he had never marked out for himself.

The subject of the lecture before us is Stricture of the Urethra. Of all the diseases, coming within the range of surgery, to which the urinary organs are liable, stricture of the urethra is by far the most common. Its victims are numerous and are to be found in every locality. As the common method of treatment is only calculated to afford temporary relief, nothing but evil forebodings is in store for the unhappy sufferer. Year by year he grows worse, until worn out by suffering catheterization, bladder and kidney troubles, he at last succumbs. Most practitioners of any experience can recall several such cases. The smallest diminution in the urethral calibre in itself of no consequence or inconvenience, often sounds the death knell of our patient. A trouble so grave in its ultimate consequences should never be regarded as trivial and undeserving of the most careful attention. Incipient stricture too often goes by the name of "gravel," to be treated by diuretics, thus seeking to overcome obstruction by increased force which is absurd. Catheterization next follows, sometimes with a view to gradual dilatation, but more frequently for the purpose of affording temporary relief from retention. It is cheering to learn from such an eminent authority as Sir Henry Thompson that nearly all cases of stricture are more or less within the range of surgical control. We can do

no more than touch upon a few of the more practical points discussed in this important lecture.

For a simple stricture or narrowing, *the history of which is recent*, nothing need be done beyond gradually restoring the calibre of the canal to its normal state by means of flexible bougies, and for this purpose the style of bougie called "oliveaire," is the one recommended, to be followed in severe cases by polished steel dilators. By the use of these or other dilators, according to the fancy of the surgeon, we are assured the normal calibre of the canal may be maintained in a large number of cases for a long period. When the passage has been restored it should be maintained so by an occasional regular use of the bougie by the patient himself. Congenital, organic, as well as acquired narrowings of the external meatus, and near to it, will not yield to dilatation. An incision is necessary in such cases. Strictures also within three or four inches of the orifice do not benefit much by dilatation. In after life when all the tissues become more rigid, dilatation is less effective. But it sometimes happens that this rigidity is absent even in the aged, and hence dilatation should first be tried. A decided tendency to contract, at any period, despite treatment by dilatation, calls for internal urethrotomy without delay. Prompt action will save much suffering, avert perineal abscesses, fistulæ, and organic changes in the bladder, ureters and kidneys. To delay until symptoms of such troubles appear involves complicity in a course which irretrievably damages the patient's life.

How to ascertain the extent and situation of the stricture, before attempting to divide the tissues which constitute it is the next point discussed. For this purpose nothing is better in the majority of cases than a bougie just large enough to pass through the stricture. In exceptional cases it may be desirable to use a series of solid bulbous-ended instruments, of which the stem is slender. Next follows a description of the urethrotome used by the lecturer. The mode of operation is then minutely described. The instrument should be constructed so as to cut from behind forwards.

The question is next asked and answered, what are the results of internal urethrotomy in relation to the reappearance of stricture? It is not possible to promise immunity from return. Great stress is laid on the necessity of *complete incision* of the con-

tracted tissues. The rule is that sooner or later the stricture will return. But in the meantime the patient has been placed in a condition of health and comfort for several years, saving him the suffering and organic changes which threatened his existence. When the trouble returns division can again be resorted to. It is not a dangerous proceeding, necessarily occasioning hesitation on the part of the patient when his condition requires it. As in the case of stone, stricture is to be dealt with as often as the case demands. In this way the implication of vital organs is avoided, and the patient is permitted to live out his days in comparative comfort.

The risks of the operation are small. Sir Henry has operated on about 340 patients. The number of operations must have exceeded the number of patients by several hundreds. Of the 340 on whom the operation was performed, six only died, or less than two per cent. Three of the deaths were due to pyæmia; one to embolism; two to extravasation and exhaustion, one of the latter being unfit for operation.

Such is a brief summary of the views of one every way qualified to speak; and such are the results of his long and wide experience. The low rate of mortality will be a pleasant surprise to many. Every surgeon cannot hope for results so satisfactory, yet we are convinced their publication will go far to disarm fear, and give such a stimulus to this branch of surgery as will diminish the suffering and brighten the hopes of many a doomed victim.

BRITISH MEDICAL ASSOCIATION.

The fifty-second annual meeting of the British Medical Association was held in Belfast, beginning on the 29th of July, under the presidency of Dr. James Cuming. Additional interest was imparted to the proceedings by the presence of a number of distinguished foreigners both from Europe and America—Profs. Benedikt of Vienna, Zehender of Roostock, Cordes of Geneva, Drs. Pozzi and Du-jardin-Beaumetz of Paris, Gayet of Lyons, Drummond of Rome, Grant Bey of Cairo, etc., from the continent; and Drs. Flint, Sayre, Jacobi, Billings, Moore, Jones and others from the United States. Drs. Geikie, Douglass, Graham and McFarlane were present from Canada. About six hundred members attended the meeting. The president's

address was on "The General Character of Epidemics," in which he referred to the present epidemic of cholera, and urged due vigilance on the part of the profession and the government. The subject of micro-organisms and their relation to disease was also considered. On the following day Dr. Sayre gave a demonstration of the application of the plaster jacket in curvature of the spine. The address on medicine was delivered by Dr. Ord of London, who took for his subject "Some Perversions of Nutrition caused by the Nervous System." He alluded especially to muscular atrophy dependent upon articular disease—Charcot's disease, rheumatic arthritis, gonorrhœal rheumatism, etc. The address on surgery was delivered in the surgical section by Sir William McCormac, in which he reviewed the advances made in "Abdominal Surgery" during the past five years, relating his own experience in two successful cases of gastrostomy for malignant disease of the œsophagus, sixteen cases of the radical cure for hernia performed as a sequel to herniotomy, and one of excision of a large goître. His method of the radical cure of hernia was to excise the sac, and ligate the neck, suturing the ring. The address on obstetrics was delivered by Dr. George H. Kidd of Dublin, taking for his subject "Puerperal Fever." With regard to etiology, he claimed that it was due to either or both of two causes—traumatism or epidemic influences. The address on physiology, which was a most able and interesting one, was delivered by Prof. Redfern of Belfast, and was well received. He dwelt chiefly on the progress of physiological science and its influence in medicine and pathology.

The work of the sections was characterized with earnestness and energy. The social aspect of the meeting was as agreeable as it was varied. The citizens of Belfast spared no pains to make their visitors happy. Public and private entertainments took place every evening, and excursions were made on Saturday to the Giant's Causeway, Gar-ron Tower, Newcastle and other places. Dr. W. T. Edwards was elected President for the ensuing year, and Cardiff, South Wales, chosen as the place of meeting in 1885.

DR. KOCH has been decorated by the French Government with the *Legion of Honor*, in recognition of his services in the French cholera district.

THE INTERNATIONAL MEDICAL CONGRESS.

The eighth session of the International Medical Congress was formally opened in Copenhagen on Sunday the 10th of August, by the president, Prof. Panum, of Copenhagen, in the presence of the King and Queen of Denmark, the Council of State, and the King and Queen of Greece. The attendance comprised about 1600 medical men of all nationalities, including about 100 English and 50 Americans. The *Medical Record*, of New York, with characteristic enterprise, gives a cable report of the proceedings, from which we glean the following. An address of welcome was delivered by the president, followed by a brilliant reply from Sir James Paget in behalf of Great Britain, Prof. Virchow in behalf of Germany, and Pasteur in behalf of France. A grand banquet was given in the evening. On Monday the work was inaugurated by the division of the Association into sections, sixteen in number. Prof. Pasteur delivered an address in the general session on "Micro-organism and Vaccination," in which he referred to the report of the French commission, stating that of twenty-three protected dogs bitten by rabid animals in June last, all remained healthy, while of seventeen unprotected animals similarly bitten, fifteen went mad. He emphasized the practice of inoculating dogs only, and said if they were protected the disease would die out. Very interesting addresses were also delivered by the chairmen of sections and many excellent papers read and discussed. On the third day Prof. Tommasi Crudeli, of Rome, read an address before the general session on "The Nature of Malaria," and the means of making malarial countries healthier. Many interesting and valuable papers were also read before the different sections, too numerous to mention. The fourth day was devoted to excursions, one of which included a visit to Elsinore, the assumed scene of Shakespeare's tragedy of Hamlet.

It is expected that the next session of the Congress will be held in America, the invitation on behalf of the American Medical Association, through Dr. Billings, having been very cordially received. If so, our American confrères know well how to make it a success.

NEWSPAPER PARAGRAPHS.—Since our last issue we have received a number of newspaper paragraphs, containing reports of wonderful and rare "surgical operations" performed by medical men in different parts of the country. Some of these paragraphs are written in a style which makes only too apparent the source of their paternity. Others again are written in such a way that we may assume that they are the work of the "reporters." But it must be remembered that the code holds the medical men concerned responsible if their names constantly appear paraded in this way. In many of the towns and cities in this Province, and in other parts, medical men have been obliged to remonstrate against their names being used in connection with paragraphs such as above referred to.

Apropos of the above, the *Medical Times & Gazette* gives the following:—Members of the medical profession who have with reason made frequent complaints in our columns of the unprofessional advertisements appearing in the daily newspapers, will be glad to learn that, so far as the Royal College of Surgeons of England is concerned, an important step has just been taken calculated to check these practices by the removal, by resolution of the Council of that College, at a meeting on the 5th instant, of one of its Members, viz., Mr. George Washington Evans, who has, after careful enquiry and due deliberation, been judged by the Council to have been guilty of an offence against the by-laws of the College by the issue of advertisements and pamphlets declared to be "prejudicial to the interest," and "derogatory to the honour of the College," and "disgraceful to the profession of Surgery." The effect of this resolution will be that the name of George Washington Evans will also be erased from the Medical Register.

ONTARIO MEDICAL ASSOCIATION.—In accordance with a resolution passed at the last meeting the chairman of each temporary committee is expected to open a discussion next year on some subject to be named. The following are the subjects chosen:—*Surgery*—Chairman, Dr. Powell, Edgar—Subject: "Plaster Splints and Bandages." What fractures are best treated by them in private practice? What their advantages and what the dangers and limitations of their use? *Medicine*—Chairman, Dr. Tye, Chatham—Subject: "Diphtheria." *Ophthalmology*—Chairman, Dr. Ryerson,

Toronto—Subject: "On the use of Jequirity in affections of the eye." *Obstetrics*—Chairman, Dr. Temple, Toronto—Subject: "Intra-uterine medication."

CHILDREN'S TONIC.—The most pleasant and palatable disguise for quinine may be extemporized as follows:

R—Quiniæ sulph.,	grs. xl.
Acid tannic,	grs. xx.
Tinct. opii camph.,	℥ ss.
Tinct. cinchona,	℥ ss.
Spts. lavender co.,	℥ iij.
Syrup simp., ad.,	℥ iv.—M.

Shake well before using. The dose will be usually one teaspoonful three times a day, but the amount of quinia desired to be administered should govern the size of the dose. It will make a beautiful creamy mixture, if the quinia and tannin are rubbed together on a pill tile or a sheet of paper with a spatula until all lumps disappear, then put in a suitable bottle and first add the paregoric, shaking at once, then the cinchona and lavender, followed by the syrup.

DAVOS-PLATZ AS A HEALTH RESORT.—The merits of Davos-Platz, Switzerland, as a health resort are becoming more and more appreciated by the highest medical authorities of Great Britain. The place possesses the great advantage of salubrity at all seasons of the year, so that patients may be sent there the moment it is discovered that their health requires the aid of its pure, bracing, dry and rarified air, and can remain without interruption until their recovery is complete. Good accommodation, suited to the habits and wishes of English visitors, may be had at the Hotel Belvedere, under the management of Mr. Cöester, who will gladly furnish any information that may be desired.

BRITISH DIPLOMAS.—The following gentlemen have successfully passed the examination of the Royal College of Surgeons, England, and were admitted members—Drs. H. W. Aikins (Toronto); C. E. Gooding, G. B. Rowell, and J. B. Loring (McGill). The following have taken the L.R.C.P., London:—Drs. G. L. Airth, W. M. Brown, and E. H. Williams (Trinity); E. E. Bronstorff and A. Stewart (McGill); and J. F. Bell (Toronto). The following have received the double qualification of

L.R.C.P. & S., Edin.:—Drs. S. A. McKeague, W. E. Sprague, J. Johnstoa, O. M. Belfry, R. Ovens, A. S. Thompson, and E. T. Eade (Trinity); J. Hutchison and W. Porteus (McGill).

ANOTHER CHOLERA COMMISSION.—We have had the French commission and the German commission, and now at the eleventh hour we are to have an English commission. Prof. Klein and Dr. Gibbes are to proceed to India and study the nature of cholera, and to act in conjunction with a native commission recently appointed. The gentlemen named are well qualified for this important work and their investigations will be of service to the world, but we fear that the earlier German commission has robbed them of whatever distinction they might have obtained in their investigations.

TREPHINING IN EPILEPSY.—Dr. Briggs, of Nashville, read a paper at the recent meeting of the Am. Surgical Association (*Am. Pract.*, July), in which he claims the most brilliant results from trephining in epilepsy arising from traumatic causes. In his record of 30 cases, he gives 25 cured, 3 relieved, 1 not benefited, and 1 died. No antiseptic precautions were used. Such results clearly indicate the propriety of resorting to the operation.

A GOOD DIURETIC.—The following combination recommended by Dr. Fothergill, will be found a useful diuretic:

R	Pot citrat.	℥iiss.
	Spt. Juniper Co.	℥j.
	Tr. Digitalis	℥iiss.
	Inf. Buchu. ad.	℥viiij.—M.

Sig. One to two tablespoonfuls three or four times a day.

MEDICAL LIFE PEERS.—An amendment has been proposed to the British Medical Act Amendment Bill, to the effect that two physicians of over twenty years' standing be made life peers, and act as lord justices of appeal in medico-legal trials. Some such measure has been frequently urged by members of the profession in England, and if carried out will considerably strengthen the hands of justice.

The passing of the British Medical Bill has been again postponed till a more convenient season.

HONORS TO CANADIANS.—Dr. Osler, of Montreal, is an applicant for the chair of clinical medicine in the University of Pennsylvania, made vacant by the transfer of Dr. Pepper to the chair of medicine. Should he be appointed the loss to McGill College will be seriously felt. He has also been invited to deliver the Gulstonian lectures before the Royal College of Physicians, London, next spring.

APPOINTMENTS.—Dr. J. M. Cochrane, of the assistant staff of the Toronto General Hospital, has been appointed medical superintendent of the Hamilton City Hospital. We congratulate our young friend and also the Hospital upon this excellent appointment.

Dr. J. McDonald has been appointed to inspect all vessels arriving in the ports of the Miramichi District, N. B.

APPLICATION FOR DIPHTHERIA.—The following will be found a most useful formula :

R—Liq. ferri subsulph.,	℥ iv.
Acid carbol.,	℥ j.
Sodæ sulphit.,	℥ iij.
Glycerini,	℥ ij.
Aquæ, ad.,	℥ iv.—M.

Sig.—Apply by means of a brush or swab every two or three hours.

PRURITUS VULVÆ.—Dr. William Goodell, of Philadelphia, prescribes for this disease : carbolic acid, one drachm ; morphine sulphate, ten grains ; boracic acid, two drachms ; vaseline, two ounces. Also, pat the parts with a sponge soaked in boiling-hot water. This is also a most excellent application for that rawness so often found between the thighs of the newly born.

HYDROPHOBIA INOCULATION SUSTAINED.—The commission appointed to consider the question of the prevention of hydrophobia by inoculation as advanced by Pasteur, has reported in favor of the correctness of the distinguished scientist's theory.

The death of Prof. Jäger, of Vienna, the distinguished ophthalmic surgeon, is announced ; also Sir Erasmus Wilson, of London, the well known dermatologist.

Books and Pamphlets.

THE AMERICAN SYSTEM OF PRACTICAL MEDICINE. Edited by William Pepper, M.D., LL.D., Philadelphia. In five volumes, with illustrations. Volume I., now in press. Philadelphia: H. C. Lea's Son & Co.

The publishers have just announced this magnificent work. For three years it has been in active preparation, and it is now in a sufficient state of forwardness to justify them in calling the attention of the profession to it as the work in which for the first time American medicine will be thoroughly represented by its worthiest teachers. A reference to the list of contributors will show the generous rivalry with which the most distinguished men from all the prominent centres of education, and from all the hospitals which afford special opportunities of study and practice—have united in bringing together this vast aggregate of specialized experience.

THE FIFTH ANNUAL REPORT OF THE ILLINOIS STATE BOARD OF HEALTH, for year ending 1883. Springfield, Ill. : H. W. Rokker.

The annual report of the Board contains be the proceedings of the meetings, a mass of information on medical education and the regulation of the practice of medicine in the United States and Canada. It contains a digest of the medical and institutions in each of the several States of the Union, and also in Canada ; a list of Medical Colleges, Post-graduate Institutions, number of Physicians and Students, etc. It also contains a list of small-pox epidemics, vaccination, mortality statistics, and nomenclature of diseases, together with meteorological tables, all well indexed.

STUDENT'S MANUAL OF ELECTRO-THERAPEUTICS by R. W. Amidon, A.M., M.D., Lecturer on Therapeutics at the Woman's Medical College, New York ; pp. 90. New York : G. P. Putnam's Sons.

This unpretentious little work aims at presenting, in the most concise language, that information necessary to the proper understanding of the construction and use of medical batteries. It also contains with the proper application of electricity in different pathological conditions, and the method of electro-diagnosis.

*** The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

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AN ADDRESS ON ABDOMINAL SURGERY.

BY LAWSON TAIT, F.R.C.S.E., BIRMINGHAM, ENG.*

Mr. President and Gentlemen,—Every gardener knows that a plant long grown on the same soil rises or sinks or somehow or other gets to a level from which it varies not so long as its conditions remain the same, and he knows as well that if he takes that plant to a new soil which suits it—if he grows it under new conditions—its growth, change, and development are practically endless. What we know of plants is, within limits, true of humanity; and if we require proof and illustration of this, where need we go but to this endless continent of yours.

I am not at present concerned with natural boundaries created by languages which come from Sweden and Poland, Denmark and Scotland, Russia and Ireland, which temporarily limit intercourse between different peoples who perhaps settled here. Still less do I trouble about a line on the map which marks a practical Republic on the south from a splendid Democracy on the north. I have only to do with the great fact of human history—I think the greatest fact—that from out of the troubles and distresses of our eastern countries, or out of countries oppressed by over-population, and still more by the effete policies of governments of past centuries dislocated into modern life, from these there has come a great country and a great people, whose growth, change, and development promise to be practically endless. Of my own country and my own people you will not expect me—you would not wish me—to say anything disparaging. We are an old and a respectable race, and, by virtue of your descent, you share that age, and you have brought over with you a

full measure of the respectability. But in transit you have lost that questionable virtue of extreme conservatism which we retain in every conceivable phase of life. We used to have mail coaches protected against robbers by armed men, properly called guards, and we continue to call our railway servants guards without the slightest reason save that they seem to be in some fashion successors to the blunderbuss-bearers of the eighteenth century. On the other hand, you very properly call the same officials conductors. We still build our railway carriages in compartments fitted to hold six people, confined boxes that are stuffy, inconvenient, wasteful of room, and dangerous, and we do this only because one hundred years ago we built our stage coaches on the same pattern, and we thought, and we continue to think, that by sticking three of these old coaches end to end we must of necessity construct the very best kind of vehicle for railway travelling. Untrammelled by tradition, you have continued to build carriages far more convenient and suitable in every way. You have even sent them over to England for our use some ten years ago, but they had actually to be removed from our railways because the public would not use them. I might gather further illustrations of this intensely conservative spirit which governs everything English. I might wander into the regions of politics and religion and hundreds of other sources, but I prefer to take one of which I can speak at length and in detail—one upon which I believe, if I read aright the compliment you pay me by asking me to appear here before you, I can speak with some authority.

In my youth the medical education of a British student was not considered complete unless he had made a tour of the schools of France and Germany, and, like others, I felt of myself as was said of Proteus:

“ ’Twould be a great impeachment to his age
In having known no travel in his youth.”

But I wish now that the time and money therein spent had been directed to the western instead of to the eastern continent. And I now predict that ere long it will be to the medical schools of America that our students will travel, as did the apprentices of old before they settled down to the serious exercise of their craft. For many years past I have been visited by numbers of my professional brethren from this side the Atlantic, many of whom

* Delivered before the Canada Medical Association, August 26th, 1884.

have settled down for days and weeks, and even months, to see my work. I have been overwhelmed by the kindest invitations to visit this continent, but till now I have never ventured across. This delay is an instance of British conservatism, for it is very little the fashion amongst us to take long holidays. I have not had a holiday for seven years, and only the most eminent doctors in England take an annual outing; but on this side I find that none of you think much of a trip across the water, involving leaving your businesses for three or four months, and, from what I have heard, the struggle for existence is as keen as it is with us, perhaps keener. My American visitors have, one and all, impressed me with the feature of mind which I fear in England we do not possess—the power of judging any question solely upon its merits, and entirely apart from any prejudice, tradition, or personal bias. No matter how we may struggle against it, tradition rules all we do; we cannot throw off its shackles, and I am bound to plead guilty to this weakness myself, perhaps as fully as any of my countrymen may be compelled to do. I may have broken free in some few places, but I know I am firmly bound in others; and my hope is, that my visit to a freer country and a better climate may extend my mental vision.

To come to my intended illustration, let me briefly remind you of the early history of abdominal surgery. The first operation for the removal of an ovarian tumor was performed unwittingly, in 1701, in a Scotch village; for Robert Houston began there a tapping, and finished by making a successful ovariectomy. It was not till 1809, eighty-six years after Houston's case was published, that his example was imitated, and even then it was not in Europe, but in the fresh soil of the backwoods of Kentucky that the young seedling obtained its first full growth, and from that time and from this country dates the history of abdominal surgery. But how slow the growth! In 1863 I heard my master, the Professor of Surgery in the University of Edinburgh, settle all this vast field of human progress in these few words: "Abdominal surgery is abominable surgery." Syme, the greatest surgeon by far with whom I have ever come in contact, shared the views of his colleague in this matter, and I fear that in both the sentiments originated far less in the merits of the question than in their mutual dislike (almost the only sen-

timent they had in common) of John Lizars, who, having read Macdonald's manuscript when it was sent to John Bell, was immensely struck by the success of the heroic Kentuckian, and was desirous of following his brilliant example. Most unfortunately for humanity, the success of Lizars was of a very doubtful kind, and abdominal surgery had to wait for the advent of Dr. Charles Clay and Mr. Isaac Baker Brown. The story of the latter brilliant and unfortunate surgeon is now a twice-told tale, and I can only repeat what I have said at length elsewhere—that his disastrous downfall was a misfortune for humanity, delaying as it did the progress of abdominal surgery for fully a quarter of a century. The whole question of this progress lay in the peculiarly narrow issue as to whether the pedicles of ovarian tumours should be dealt with inside the peritoneum or outside it. Here, again, the new country was first in the race; for between 1820 and 1830 the decision in favour of the intra-peritoneal treatment was given in America in such a way that the question ought never to have been reopened. The arbitrament of abdominal surgery between 1866 and 1876 was left in the hands of a man still living, and he carried through his practice a mortality so heavy as to be absolutely prohibitive of fresh enterprise. Mr. Baker Brown left off practice in 1866 with a mortality of ten per cent. with the cautery, whilst, after operating on a thousand cases, Mr. Spencer Wells had a mortality of twelve per cent. in the last hundred with the ligature, and over the whole thousand the mortality was exactly twenty-five per cent. With such results as these, the marvel is not that the conservative surgeons cried out twenty years ago that the craft was in danger, but that the removal of ovarian tumours ever became an accepted operation at all. As I have said over and over again, as I shall never tire of saying, to Keith is due the whole credit of the modern development of abdominal surgery, and it has ever seemed to me specially hard that while wealth and a title has been the lot of the man who had done nothing but obstruct progress, yet to the author of our present proud position, nothing has come save a good deal of misrepresentation and abuse. In 1878 the doctrines and practice of Lister, after twelve years of preaching on the part of Mr. Lister, had penetrated to London and were taken up by Mr. Wells and his assistants. I had practised all the details in

their ever-varying form, as recommended by Mr. Lister, from 1866 onwards, and gave them up one after another as I found they disappointed and hindered me. Finally I gave the spray and its adjuncts a long and complete trial—a trial far more careful in its details than anything I ever saw elsewhere, extending over three years. I have published in detail the disastrous results of this experiment, and at last gave up all these unnecessary dangers, and, since January 7th, 1881, my practice has been entirely free from all these details. Since then my example has been followed by Dr. Keith, Dr. Bantock, and by my colleague, Dr. Savage, and the only surgeon now who uses the Listerian details for abdominal surgery is Mr. Knowsley Thornton. He still claims for Listerism the most of our present progress, in spite of the fact that Keith, Bantock, Savage, and myself have all far better results without Listerism than Mr. Thornton has with it. Mr. Thornton went so far recently, as to say that his (Mr. Thornton's) bad results in hysterectomy were due to the fact that in this operation the Listerian details could not be effectually applied. But the facts of the practices of Mr. Thornton and Dr. Bantock, the two surgeons to the Samaritan Hospital, settle this question when they are contrasted. Mr. Thornton uses the Listerian details for hysterectomy as well as he can, and in twelve cases he has had five deaths, while Dr. Bantock does not use the Listerian details at all, and in twenty-two cases he has had only two deaths. The explanation of the difference will be evident to every one who has seen both of these gentlemen operate. To see Dr. Bantock do a hysterectomy is a lesson in surgery, and one from which I learnt a good deal.

To see my own work, I have been honoured with the visits of a large number of surgeons of this continent, some of whom I see here now. I believe they, one and all, came with a belief that they would find I had some secret antiseptic agent, the use of which was the explanation of my success. If I have such an agent, it must be of universal existence in nature, for I have made some of my visitors take the water from the tap and put it into the basins for the sponges, and over the instruments and into the abdomen. I have made them drink it, and have offered it to them for analysis, and, so far, I have not been detected in

any magic exercise. My visitors always ask to what I attribute my success, and I answer that I cannot tell. They frequently suggest that it is climate. My answer is that our climate is the most variable and uncertain—the worst in the world. It is not fresh air, for the great majority of my operations, and always the worst, are done right in the middle of a large manufacturing town.

If I may formulate my own answers, they would be briefly to this effect: I have given up my life to this work, and I engage in no other kind of practice; therefore I have a constant weekly experience of five or six of these operations, sometimes as many as eight or ten. I pay the most minute attention to every detail, and maintain an absolute rule of iron over my nurses and my patients. I will not, if I can avoid it, operate in a private house, for there I have no control over either nurse or patient, still less over foolish friends. I can best illustrate the extent to which I carry discipline by telling an incident which occurred recently of a kind of which I have had a few, but not many, experiences. For my private hospital I have a rule that when a patient is admitted she must go to bed immediately. A lady with an ovarian tumour arrived, after a journey of some hundreds of miles, and was asked by the nurse told off for her, to go to bed. She said she would not do so until she had seen me. The nurse assured her that I would not come near her till she was in bed. The patient remained obstinate and I sent a message to her that she must either go to bed or go home again, and she elected to do the latter, with much satisfaction to myself. She doubtless thought and you may think, the rule in question is an absurd one, but the absurdity is only on the surface. It is a test of the patient's obedience and confidence in me, and I know very well that with a patient who begins by disputing my orders and doubting the wisdom of my directions, I never could get on, and therefore it is better for both that we should have an early parting. My nurses I always train myself—in fact, I will not have one who has had previous experience, for I know very well that such a woman will inevitably, to save herself trouble, do something in a way she has done elsewhere, and probably for some purpose altogether foreign to my intention, and will therefore become to me a source of danger and annoyance. Finally, I give great personal attention to

cleanliness in every detail of my work. I trust no nurses or servants without overlooking, and am constantly and at unexpected times turning up carpets, taking down shelves, and rooting out cupboards. In this way, and by a process of weeding, I have obtained a large staff of good servants, and have formed a large establishment in which every available precaution is secured. I can give no other reasons than these for my success, and probably they will commend themselves to you.

There are some causes intrinsic to the work itself from which the success has sprung to a large extent, and of which a few words may here be said with advantage. The first, of course, is the discontinuance of the clamp, of which I have said a great deal elsewhere. Whatever Sir Spencer Wells may say to the contrary, neither with nor without Listerism would anybody go back to the clamp. But the curious thing is that, from our recent experiences in hysterectomy, it would appear that it is not so much the clamp that has been to blame as Mr. Spencer Wells' method of using it. Hysterectomy must always be a more serious operation than an ovariectomy. But Dr. Bantock has now obtained better results in removing the uterus with the clamp than Mr. Spencer Wells ever got in removing simple ovarian tumours, and we must bear in mind that Mr. Wells always insisted that he used the clamp for his simplest cases with long and easy pedicles. Puzzling over this mysterious and startling contrast, I went to see Dr. Bantock operate, and amongst other things I found he had given up using perchloride of iron for the purpose of tanning the stump. I asked him why he had done so, and he told me he was quite sure that the use of the perchloride of iron had added greatly to the mortality of the clamp, because with a thick pedicle secured by a clamp it is impossible to accurately close the abdominal wound and prevent draining into the cavity. I did not at once accept Dr. Bantock's explanation, but I determined to use the perchloride no more. Like everybody else, I was prejudiced in favour of the statement made by Mr. Spencer Wells, that a putrefying stump would poison the wound; and therefore I could not make up my mind to allow it to remain without some kind of interference. Years ago, in blaming the clamp for our high mortality, I had pointed out the likelihood of this incomplete closure as being one of the causes, if not

the chief cause, of death; but I certainly did not suspect the perchloride of iron as being the fatal agent. A few days after my interview with Dr. Bantock I had to perform a hysterectomy, and I dressed the stump with crystals of thymol. The patient died of peritonitis on the fourth day, and that the thymol had trickled into her peritoneum we had proof enough. Since then I have done a hysterectomy without dressing the stump at all, and the patient has done perfectly well. It will be curious and no less instructive, if we find Dr. Bantock to be right, and that the use of perchloride of iron, the only contribution Sir Spencer Wells has ever made to abdominal surgery, should turn out to be the cause of his tremendous mortality. In any case, it is a remarkable example of how absurdly we are all governed by *a priori* statements absolutely void of any argument in support of them, and having been made by some one with an authoritative name and position, are accepted without doubt. If Dr. Bantock's brilliant results are obtained by others in the same way, then we have been going on destroying women with perchloride of iron merely because Mr. Spencer Wells said we should use it.

As the whole aspect of abdominal surgery is, at the present moment, controversial—as the progress and practice of this part of our art form the chief objects of my life, you need not be surprised if I have made this address somewhat of a polemic. The greatness of the opportunity—the fact that an address given to you will be read where mere utterances of mine would be passed by—obliged me to take advantage of the opportunity you have given me to carry on the discussion. The course of this particular line of work has, as you are all aware, taken a sudden bound of activity within the last few years, and the reason is a very simple one. The immense success of the removals of ovarian tumors such as threatened to destroy life with absolute certainty, which followed the efforts of Baker Brown and Keith, led some of us, myself especially, to venture into regions where life was not necessarily, or, at least, not apparently threatened, but where suffering was persistent and unendurable, and where the sufferers had been proved by protracted trial to be outside the powers of ordinary remedial measures. In a recent paper by Sir Spencer Wells, published in the *Med. Times and Gazette*, the argument is completely dislocat-

ed and put in an altogether *outré* fashion, and therefore I must here give a little attention to the views of that writer. He tells us that ovariectomy had, at one time, a mortality of 70 or 80 per cent., but I know not whence he gets his information. Doubtless it would be possible to find occasional examples of surgeons with a limited experience having such a heavy death-rate, but such isolated cases would not yield a fair statement of the facts. I read a few months ago in an American medical journal that in Italy there had been 100 cases operated upon with 53 deaths, and the newspaper recorded the fact that 34 surgeons were engaged in the sanguinary work. But when the work of men who can be called ovariectomists is examined, no such results are seen. Charles Clay was the first man who did ovariectomy in England, and his maximum of mortality in his first series of cases was 40 per cent., and it speedily fell to 25 per cent., and this is pretty much what has been recorded by Sir Spencer Wells of his own practice.

In the paper of which I am speaking, Sir Spencer goes on to say that "afterwards, when the strictest hygienic precautions were supplemented by antiseptics, and improvements in operative details were generally adopted, success became so great that ovariectomy not only took its stand as by far the most successful of any capital operation in surgery, but the risk attending it in a favorable case could truly be calculated as little, if at all greater, than that attending any case of natural child-birth, and, as a necessary consequence, early operations can be advised with less hesitation." The statements in this quotation are wrong from beginning to end. In the first place, the mortality of ovariectomy in the hands of Keith and myself still remains at or about three per cent., and we have shown the least mortality yet available. The mortality of natural labor, on the other hand, is certainly not .25 per cent. The statement that a diminished mortality has led to early operations ought to be exactly reversed, for it is the early removal of tumors and the discontinuance of tapping which have largely contributed to our present splendid results. Sir Spencer Wells' teaching inculcated the practice of tapping and its repetition until the patient was within measurable distance of the grave, but his successors have reversed all this with infinite advantage to their patients, and we now look upon tapping as a sort of surgical

crime. This material alteration in practice led us, step by step, in the direction I have indicated, and we began to discuss the greater advantage to which I have just alluded. Every specialist is familiar with the large class of miserable women who wander about from hospital to hospital, or from consulting-room to consulting-room, seeking relief from their ailments unavailingly.

Let me take the first class to which Sir Spencer Wells alludes in his recent paper on cases of uterine tumor. There can be no doubt but that there are hundreds of uterine tumors that give no trouble at all, but these are not the cases that come to us. If a woman has no pelvic trouble, she does not present herself to the gynæcologist, and if she has a uterine tumor which gives rise to no symptoms, that tumor, of course, remains undiscovered. But when she suffers from distress occasioned by pressure on the viscera, from severe hæmorrhage, or increasing size, she comes to us and asks for advice. Suppose we find her suffering from a uterine myoma, what are we to do? The answer to this question is like the answer to every other of a similar kind. If the tumor is small, the woman comparatively near her climacteric, and the hæmorrhage such as can be moderated by rest in bed and the use of ergot, then she can be advised to let the tumor alone; but if the woman be not near her climacteric, and the hæmorrhage does not yield to treatment, especially after a fair trial of treatment, the tumor is found to be actually going on, then surgical treatment is demanded. Of course, each practitioner of medicine does, and always must, carry on his work in his own way, and there can be no doubt that within certain limits the measure of his success stamps the rightness or the wrongness of his methods. James Syme used to teach us that there were three methods of conducting our professional business, but that there was only one way to real success. He said there were three interests involved. The first in order is that of the patient; second, that of the professional colleague; and third, that of the practitioner himself. Syme insisted that the several interests should be rigidly kept in the order in which he placed them, or things would be sure to go wrong. I have never heard sounder advice. I have never lost sight of it, and so far as within me lay I have striven to follow it. In the proposal of a new proceeding two dangers clearly occur. The first is that of the

enthusiastic upholder of the novelty; he may be disposed to run too fast on the new line. The second is that of the obstructive who, merely a believer in the times that are past, can see no possibility of their improvement. For the first danger the remedy is a wholesome scepticism, leading into just and careful criticism; the remedy for the second is more difficult, for it involves the patient endurance of much misrepresentation, and a protracted combat upon the points of criticism which have no weight in themselves, and have an importance gained only by persistent reiteration. In the line of practice of which I am about to speak, the point most persistently urged against our new line of practice is that unnecessary operations are performed. Now, this is an argument which it is extremely difficult to argue upon, because those who speak on the two sides of the question start from altogether different standpoints. Those of a past generation, like Sir Spencer Wells, apparently regard it as justifiable to perform operations in this department of surgery only when life is pronouncedly in danger; we, on the contrary, of the younger school, believe we are justified in extending our practice for the relief of suffering, and we regard this as a higher function than that of the mere saving of life. To end the discussion on this point, I would point out that our critics endeavor to apply an arbitrary rule for the repression of abdominal surgery which has never yet been applied in any department of the art. Let me ask, if we find a man suffering slightly with the early symptoms of a small calculus, do we not at once proceed to relieve him by removing it from his bladder? In fact, in the domain of what is called general surgery, has it not become the established practice to perform operations which are accompanied by very considerable risk of life merely for the rectification of deformities, such as bowed-legs and knock-knees, which have not the remotest risk of life attached to them and which involve no kind of suffering. The ultimate court of appeal comes then to be the patient's own decision, and I do not find that persons prefer to go on suffering pain and the disabling effects of profuse loss of blood rather than submit to a surgical operation, the details and effects and ascertained risks of which are completely and candidly placed before them.

In the treatment of uterine myoma two alternatives occur, and these are both the subject of very

hot discussion on my own side of the Atlantic; they are the removal of the uterine appendages, and the removal of the uterine tumor itself by the so-called supra-vaginal hysterectomy. No one in Europe, at least only one so far as I know of any importance, doubts that removal of the uterine appendages arrests menstruation completely in the great majority of cases, arrests the growth of uterine myoma generally, and in many instances causes it to entirely disappear. Mr. Knowsley Thornton, Dr. Savage, Professor Hegar, myself and others, have reported numerous cases in detail. I have published a long series in the *Am. Jour. of Med. Science*, but Sir Spencer Wells dismisses us all in the brief sentence: "Vague, unsupported assertions have little influence upon the opinion of a thoughtful or a sceptical profession." Sir Spencer Wells must pass his retirement in some other occupation than in perusing the modern literature of his specialty, and therefore his criticism need hardly engage our attention.

The great majority of cases of uterine myoma, which come to us for surgical treatment, can be quite satisfactorily dealt with, and it is an operation having a small and steadily diminishing mortality. Since 1878 I have performed it many times with few deaths, but am unable to give the exact figures just now. The arguments used against it are, first, that of its mortality, but this mortality is the inevitable result of early work, and is therefore not a permanent objection. It was an objection urged twenty-five years ago against ovariectomy, but it no longer holds good against that operation. The second objection is that myoma itself is not a fatal disease, but this argument is not in harmony with my own experience. Even if it were a just one, however, it is admirably met by the plea entered at Ryde by Dr. —, of —, in the discussion of my paper on the subject, to the effect that it is to the rights and relief of the majority that we must have regard, and that the function of our profession does not end with the saving of life, but is chiefly that of relieving suffering.

Two other objections have been urged generally against the removal of the uterine appendages—that it sterilizes and destroys the patient's sexual appetite. Of course, a woman is completely sterilized by a uterine myoma ninety-nine times out of a hundred, so that the process of complete destruction of fertility is a matter of little moment. The other ob-

jection has been shown to be perfectly groundless, but even if it were not so, it could hardly be urged on the ground of morality that a woman should go on suffering because she ought not to suffer any diminution of that animal propensity which it is the chief object of the higher life of all religious culture to subject, and the subjection of which forms for all creatures the greatest difficulty in existence.

There are cases of myoma demanding surgical treatment upon which removal of the uterine appendages seems to exercise no satisfactory influence. Mr. Knowsley Thornton has made a very valuable suggestion—one which certainly deserves very careful consideration—that all cases of myoma requiring interference are first to be subjected to the removal of the uterine appendages, and then to subsequent operation if it should be necessary. The only objection to this I can offer at present is an incomplete one. I have pretty well satisfied myself that there is one form of myoma on which removal of the appendages exercises no control. The variety I have named the soft œdematous myoma. But it is not easy to recognize this form of tumor until after it has been removed. Again, there are a few cases, very few I have found them to be, in which the appendages cannot be removed, and we must proceed to hysterectomy. Finally, the removal of uterine tumors has had such brilliant results in Bantock's hands that I am in hopes that a new era for hysterectomy is being opened out.

Another class of cases wandering about after relief are those upon whom I have operated in large numbers, and have found chronic and incurable disease of the appendages in the form of chronic inflammation of the ovary, chronic inflammation and occlusion of the tubes, these latter being occluded and distended by serum, pus, or blood. When I first published my work on this subject there was, of course, a large amount of incredulity expressed about it, and this incredulity was not much lessened by the exhibition of a large number of specimens at various societies, and their permanent exhibition in the museums of the colleges of surgeons. Many, particularly amongst my metropolitan brethren, loudly asserted that there were no such diseases, and Mr. Spencer Wells stated at the International Medical Congress in London that if such cases did occur they must all go to

Birmingham. But Dr. Kingston Fowler has shown not only that they exist in London, but that they are far more fatal than I had any idea of, and that they have been and are overlooked and misunderstood in the metropolis just as they were overlooked and misunderstood in my own practice previous to 1878. Concerning this incredulity, please distinctly understand that I don't blame anyone for it. It is a necessary part of all human progress. I do not even blame my metropolitan brethren, as they seem to think I do, for not discovering these cases and properly treating them. That is the fault of the mechanical school of gynecology established by Simpson, and which still exercises a far too great influence over this department of our art. During the last twenty years displacements have had a great run, just as before that time everything was put down to ulceration, and no man considered himself properly armed for the treatment of disease unless he carried a speculum and a caustic stick about with him in his gig. The mechanical school revels in the sound and pessary, both useful enough instruments in their proper places, but, when misused, capable of endless mischief, for many of the so-called displacements are now known to be constituted by chronically inflamed and adherent tubes and ovaries which can be relieved by removal only.

You will ask me, at starting, to tell you how this disease may be recognized, and I have to answer that their diagnosis cannot now, and probably never will, be a matter of certainty. They begin generally in some acute attack of pelvic inflammation, from which the patient dates all her troubles; and when you get such a distinct history you ought at once to be on your guard. This illness may have arisen, for instance, in a closely-confined and confessed attack of gonorrhœa; or it may be an attack of pelvic perimetritis, occurring after a miscarriage or a labor; or it may have arisen in one of the exanthematic fevers or a simple cold. In some of the cases, however, you get no clear starting-point in the history, and then the diagnosis is generally more difficult. The symptoms are usually precise enough, yet unfortunately none of them are peculiar to the condition of which we are speaking. Pain is, of course, a leading feature; indeed, it is rarely without pain as a chief incentive that patients consult us at all. This pain is complained of as being constantly present, greatly aggravated by

walking, and becoming intense for some hours or days before the period, and lasting throughout its continuance. Menstruation is usually too frequent and too profuse. In the great majority of the cases the uterus is somewhat fixed, and a tender mass can be felt on one or other side of it, perhaps on both sides and behind it. When the tubes and ovaries are down behind the uterus and adherent there—and this is by far the most common condition—the diagnosis to a beginner is very difficult. Nothing looks more certain and easy than the diagnosis of subinvolution and retroflexion, and without further consideration a pessary is introduced, with no other result than that of aggravating the patient's sufferings; in fact, I may say that at this point her troubles will begin to be serious, and she will wander about to collect various kinds of instruments from various practitioners, until she ends either a helpless and hopeless invalid or dies from an attack of acute peritonitis. In some of my most marked and most successful cases there have been no physical signs whatever, and I have felt myself reluctantly justified in interfering only by manifest reality of the patient's sufferings.

Here let me just say a word about the much discussed question of subjective symptoms. Everybody has heard the celebrated story told of Liston—that a hysterical girl persuaded him to remove a healthy limb for supposed disease of the knee-joint. But is there any other story of the kind known? If there is, I have not come across it. We certainly do meet with women who will tell the most extraordinary and incredible stories about their sufferings; but the stories are so inconsequent and contradictory that there is no difficulty in discounting them. Besides, they have no support from the presence of corresponding physical signs. A woman whose story is real has a sequent narrative, and she will submit to treatment; while the woman who is a humbug flies off in a temper the moment the suggestion is made that she should submit to an operation in which she risks her life. I have never yet known a woman submit to an abdominal section in whom I did not find abundant justification for its performance, even in cases where I had been extremely doubtful about its real necessity before I undertook it. I have known many patients to whom I have made the proposal as a test of their reality, and who have, much to

my satisfaction, speedily taken themselves off to some other practitioner.

Of the details in these operations in these cases I have no time to speak. Indeed, I could deal with them satisfactorily only in a series of lectures. Suffice it to say that the operations are extremely difficult, for the structures are always very adherent, and the operator has nothing to guide him save the erudition of his touch. Concerning the cases of occluded and distended tubes, some of my critics have suggested, without any experience, that something short of abdominal section might suffice for their successful treatment, such as tapping the tubes from the vagina. But a trial of this proceeding long ago satisfied me of its impracticability and its uselessness, and my growing experience confirms me in the conclusion that we have no alternative. I am often asked concerning the subsequent history of these cases, and I am able to say I have published the details that the great majority of them are relieved at once and completely by the operation. There remains a tenderness of the stump in some of them for some months. In four very bad cases fæcal fistulæ formed, but in two the sinuses have healed and the patients are perfectly well. In the third case the fistula opens still at occasional intervals; and in the fourth case, by far the worst I have ever had, the patient being literally at death's door when the operation was performed, the fistula still remains, some twelve months after the operation, but even here her health has so greatly improved that I am hopeful of its permanent closure in time.

I have occupied your time already at too great length, and yet have left myself no time whatever to speak of a great variety of topics within the limits of the subject of my address of which I fain would have spoken—subjects entirely novel, and full of the deepest interest alike to the practical surgeon and to him who takes but an interest of a literary kind in the progress of our art. In fact, it is a matter of regret to me that I cannot address such an audience as this in a series of lectures rather than in an address which must necessarily be brief. It is one of the great defects of a position such as I hold—a defect inherent to a special line of practice—that it practically shuts out its follower from any chance of being a teacher. Besides this, I feel strongly as acting to my own

prejudice, and I am certain it is a misfortune that those who, like myself, are very largely engaged in work strictly limited to a department, can never communicate as successfully the results of their experience as can those who are engaged in teaching. I regret, therefore, that I must pass over without mention the important field of new work which has been opened up within the last few years in the surgical treatment of the liver, spleen, kidney, and intestines. I cannot even stop to speak of many other less striking, but no less important subjects, such as the treatment of pelvic abscesses by abdominal section and drainage, though all these are of less importance, in so far that they excite but little hostility; and what I have to say further to you I propose to limit to a brief discussion of a proposal made by Dr. Battey for the production, artificially, of the menopause for the purpose of indirectly benefiting patients from conditions more or less neurotic, the symptoms of which are apparently influenced by the recurrence of menstruation. It must be perfectly clear to the most casual observer that this is a field of an extremely ill-defined character—one which, at first sight, offers very intangible prospects of success, and in which the indications even of success must be very vague and indefinite. There can be no doubt that a large number of women suffer in such a way as to make it perfectly clear that if they were relieved from recurrent menstruation they would be improved materially, but there can be as little doubt that the application of this idea—in itself a brilliant one—requires the utmost care. I have no sympathy with stupid obstructionists who, because they scent danger in the air, would absolutely prohibit its application; but I have sufficient regard for the expression of every kind of professional opinion to recognize the necessity for the full exercise of caution. When the proposal was first made, I recognized this so fully that I selected for whatever experiments I should make in this direction a disease concerning the reality of which there could be no doubt whatever: I mean epilepsy. It is a perfectly easy thing to recognize by two facts alone any case of genuine epilepsy from mere hysterical imitation. It was, I think, Dr. John Hughes Bennett who clearly established the facts that none but the true epileptics ever seriously hurt themselves during the attacks, and that after the fits are over the epilep-

tic is always somnolent. It is certainly the case that in a large number of cases of epilepsy in women the incidence of the disease is concurrent with menstruation. It is also true that every epileptic woman, certainly whose case I have investigated, is worse during the menstrual week than at any other time. In some cases the epilepsy is absolutely limited to those days of the month during which the menstrual flow is in existence. It was, therefore, a perfectly easy thing to select a number of cases in which the experiment of Battey's operation seemed capable of justification. For the purpose of trying the experiment I selected six cases, and to these I have absolutely limited its application, though from the number of cases who have been sent to me for the specific purpose of having the operation performed, I suppose I might have been able by this time to have placed several series of attempts on record. The reason of my careful restriction has been that I did not care to prejudice the results of my other work by complicating it with what seemed to me a doubtful kind of proceeding, but all my care has been to some extent fruitless, for I have been persistently charged by a certain class of writers with having performed a large number of useless and unnecessary operations in removing normal ovaries from women suffering from nervous disorders. Indeed, so late as July 5th last, Sir Spencer Wells wrote the following sentences which, though they may have been intended for some one else, I cannot but suspect were levelled at me. They are as follows: "Just now something more than a word of caution against rash, dangerous and unnecessary operations is called for. We are startled by the reports of the removal of normal ovaries of young women suffering from nervous disorders, which may be exaggerated or imaginary; and it is to be feared that our professional honour is at stake, and that abdominal surgery in its latest developments is open to the denunciation hurled against the earlier ovariologists, and that with more reason than in 1850. Lawrence's question must be repeated, whether such operations can be encouraged and continued without danger to the character of the profession, and West's assertion that the fundamental principle of medical morality is outraged, cannot now be satisfactorily refuted."

Though I am fairly familiar with the literature of abdominal surgery during the last ten

years, I am absolutely ignorant of anything which can possibly justify such ridiculous exaggeration. I have publicly challenged Sir Spencer Wells to indicate the proceedings to which he alludes, and to produce the evidence upon which he bases his charges; but up to the moment of my leaving England he had not taken up the gauntlet. It is a somewhat remarkable fact that, in another journal of the same month, the same writer actually pleaded in favor of the removal of tubercular lungs, that such an operation would be justifiable if it saved one patient in twenty of those operated on, and it seems to me absolutely impossible to reconcile such a recommendation with the denunciation I have just read. So far as my own work in Battey's operation is concerned, in not a single one of the six patients operated upon were the uterine appendages normal. Two of them were carefully investigated by independent observers, one of whom was the well-known and accomplished pathologist, Mr. A. Doran, by whom the specimens were fully described and figured, in the *Brit. Med. Journal*.

The results of these operations were, in the first place, that all the patients made easy and uninterrupted recoveries; the operations were performed after the most careful consultation, and with the full cognizance on the part of the patients and their friends of the results which were certain, and the entire speculative nature of those it was hoped would be obtained. As I have already published the cases in detail, with the exception of the last, which was only performed a few weeks ago, I need not here repeat them, save in general terms, and that is to the effect that in two cases the results are such as to completely justify the proceeding. In both of these the disease before the operation was so intense that it was threatening life, but now it is almost entirely subdued, and the health of the patients has been enormously improved. In one case, the disease was arrested for a year and a half, and though it is now returning the patient has been transformed from a wretchedly feeble and broken-down girl into a healthy and robust woman, although affected by epilepsy almost as badly as before. In two others, the disease has been greatly modified, and the health of the patients has been immensely benefited. From this brief record it is quite a matter open for discussion as to whether the continuance of the proceeding can be recommended, and I am bound to say that I have not myself a very

strong opinion in the affirmative; but I think, if I had a daughter with feeble health, the result of pronounced menstrual epilepsy, I would advise her to have the operation performed. From what I have seen of it myself, I think there can hardly be any risk about it, and if performed with the precautions indicated, I do not think it can be brought under the sweeping category of Sir Spencer Wells as being either rash, dangerous or unnecessary. There is another argument, and I think one that may be said to have some moral force, in that it will assist in the prevention of the distinctly pronounced hereditary tendency of the disease, and we should at least hesitate before we entirely condemn it. Certainly a great deal more can be said for it than for the proposal of pneumotomy for phthisis, on the assumption that the removal of a lung would only save one patient out of twenty. Removal of the uterine appendages for epilepsy would probably not kill more than one per cent., and I am certain it would materially relieve fifty per cent.; it would improve the health of the great majority of patients, and I don't think it would make any of them worse than they were before the operation. I am hopeful, therefore, that the verdict of professional opinion will not be adverse to a fair and reasonable trial of Dr. Battey's proposal, and I trust that the freedom from the prejudice and the shackles of tradition which we find on this side of the Atlantic will secure for it a fair field.

And now, in conclusion, let me thank you most sincerely, and not only you, but many other professional bodies and large numbers of professional friends, for the kindly, I may say overwhelming, reception I have met with at your hands. For many months before I left home, there arrived hardly a mail which did not bring me invitations to partake of public or private hospitality, and these kind expressions of regard brought forth feelings of deep regret that my stay here could not be prolonged for as many months as it is limited in days. There is one thing in this reception I recognize above all others, and it is, that you are treating me not on account of any merits of my own, but as the representative of a large body of men in my own land to whom you have owed much in the past, and with whom you are in the present united in a common bond of brotherhood and community of sacred purpose. I predict that in the future this union and unity will be more and

more complete. That it ever should be endangered would be a diaster for humanity. As the blunder of a century ago, which severed from the old country her most prosperous children, kept the whole progress of the world in abeyance for nearly two generations, so any future instance would be more diastrous still. God grant that we may never see it!

Dr. Grant, of Ottawa, in a few appropriate remarks moved a vote of thanks to Mr. Lawson Tait for his admirable address, which was seconded by Dr. Brodie, of Detroit.

Dr. McMillan, of Hull, Eng., doubted the advisability of removing the ovaries when no objective signs were present. He thought that Sir Spencer Wells' remarks on this subject were addressed more especially to young men, whose experience might be less than their enthusiasm, and not to men of large experience.

Dr. Trenholme, of Montreal, said he had performed the operation of removal of the ovaries twelve years ago, in a case where there was severe menorrhagia and metrorrhagia, with marked benefit to the patient. In recent years he had performed the operation frequently, and the results were, as a rule, satisfactory.

Dr. Hingston, of Montreal, congratulated Mr. Tait on his and Dr. Keith's disuse of Listerism in abdominal surgery, and thought the splendid results they had obtained were largely due to it. He thought with the speaker that the use of the perchloride of iron was a mistake. He took exception to the criticism on Sir Spencer Wells, and thought that public opinion, which had pronounced unmistakably in Wells' favour, was not a bad criterion. He disapproved of Mr. Tait's rule as a guide to the necessity of an operation, namely, that serious cases submit to operations and the hysterical do not. His own experience was that the hysterical carried out their acting to the end, at least in America, and gave an instance in illustration, where he had been implored to remove the appendages in a young person; he declined; the patient afterwards married, and all the symptoms had disappeared. He thought that when the objective signs were clear, no hesitation should be experienced in operating; but when the signs were altogether subjective, operations would be performed that were unwarrantable. An unnecessary operation of this nature was a crime against society, and it interfered with

the interests of the state. He did not agree with Mr. Tait that the operating surgeon could place the responsibility on the shoulders of the general practitioner who had advised the operation in the first instance. He gathered from the fact that only a few (6) out of a large number of cases of epilepsy had been selected for Battey's operation, that Mr. Tait did not favor it.

Dr. Brush, of Utica, N.Y., referred to Dr. Miner's operation of ovariectomy by enucleation, and said it had been his pleasure to watch the impetus which that valuable and unique suggestion gave to abdominal surgery.

He regretted that Mr. Tait did not refer to the removal of the uterine appendages in certain cases of insanity, to hasten the menopause. Prof. Wm. Goodell, of Philadelphia, has reported a few cases in the *Am. Jour. of Insanity*, in which he had successfully performed Battey's operation for the relief of insanity in patients in whom there was marked increased mental disturbance associated with the menstrual flow. With these cases in view, and bearing in mind Mr. Tait's statement that a mortality of not more than one per cent. need be feared, he would go home with increased faith in the propriety—nay, even the necessity—of the operation, in certain cases.

Dr. Heywood Smith, of London, said he agreed with Mr. Tait as to the greater difficulty in the operation for removal of the uterine appendages as compared with ovariectomy. As to the effect of the operation on fibroid tumours, his opinion was that it was of more use in cases of soft tumours than in those of a more dense structure. He had seen cases where, after the removal of both ovaries, profuse hæmorrhage continued so as to endanger the patient's life. But in cases of severe dysmenorrhœa, the result of chronic ovaritis and subsequent morbid changes in the ovary, he was convinced that the removal of the ovaries held out the best prospect of cure. He approved of Listerism, but occasionally used eucalyptus, which had this advantage over the carbolic spray, that there was no noise nor wet fog. In reckoning the advantages of the spray or the reverse, we must be careful to estimate the growing experience of each operator, and not hastily set aside Listerism under the idea that it is useless or worse, when increased success may most probably be due to the increased experience in operating. Under the use of anti-

septic measures at the (N. British) Lying-in-Hospital in London, the mortality during the past three years had been reduced to .062 per cent. He also said that the removal of the ovaries did not interfere with the sexual appetite, nor did it make women scraggy; on the contrary, many became plump after the operation.

Dr. Gardner, of Montreal, said he had been in the habit of removing submucous myomata which caused dysmenorrhœa, menorrhagia and metrorrhagia with Thomas' serrated spoon, and would like to ask Mr. Tait if he considered the removal of the appendages safer or more effectual in such cases.

Dr. Protheroe Smith, of London said he thought that the discontinuance of bleeding, by favoring congestion of the internal organs, had made ovarian disease much more common in recent years.

Dr. Fulton, of Toronto, asked Mr. Tait if there were not cases in which tapping as an aid in diagnosis was admissible? And if in some cases where there was extreme distension of the abdominal walls, it was not safer to withdraw a portion of the fluid to reduce the distressing symptoms?

Mr. Lawson Tait, in reply, said that as Sir Spencer Wells had never hesitated about knocking other people over the knuckles, he must not expect to escape similar treatment. Mr. Tait had only to say that any criticism he had ever made of Sir Spencer Wells was with most friendly intentions, dictated by an intimate acquaintance extending over many years.

Dr. McMillan and Dr. Hingston had both somewhat misunderstood what he had said about operations performed in the absence of physical signs. Those cases were absolutely limited to three cases of epilepsy and about three others in which the operation was urged, and the whole responsibility of its performance was accepted by the medical attendant in charge of the case. Such an instance was published by Dr. Ertuby in the *Lancet* about three years ago. Dr. Ertuby pressed me to perform the operation, and undertook its whole responsibility. As we found pyo-salpinx, the operation was entirely justified. The real protection alike of patient and surgeon is the introduction of the family physician, by whose concurrence the possibility of the performance of an unnecessary operation would be reduced to a minimum. It must, however, be remembered that surgeons who

practise this department of the profession are as fallible as other human beings, and that with them mistakes must as surely occur. They are to be judged, and their works also, by the same standards applied elsewhere, and not by others of an unjust and more exacting character.

In answer to Dr. Gardner, he would say that his own experience was wholly in favor of removal of the uterine appendages as a far safer operation than enucleation. Not only so, but as fresh tumors had grown after enucleation and removal of the appendages was ultimately required, he thought that the latter operation was in every way preferable.

He did not agree with Dr. Protheroe Smith regarding the lancet. There could be no doubt that ovarian disease was on the increase, but he could offer no explanation of the cause thereof. It certainly did not lie in the discontinuance of the practice of bleeding.

In reply to Dr. Fulton, Mr. Tait had to say that tapping never could help in a diagnosis as an exploratory incision could, and it was quite as risky. A small two-inch incision revealed in most cases the precise nature of the tumour, and allowed all fluid to be completely evacuated, if nothing more could be done. In some cases of great distension the removal of fluid before operating was advisable.

CASE OF ANDROGYNÆ.

BY J. ALGERNON TEMPLE, M.D., M.R.C.S.

Prof. of Obstetrics and Diseases of Women and Children in Trinity Medical College, Toronto, etc.

A few days ago a peculiar case of malformation of the genitals in a female, came under my notice.

Mrs. D., aged 23, married 5 months, consulted me for amenorrhœa. The build of the patient was decidedly masculine, her voice deep, and a considerable quantity of soft dark hair on her upper lip and side of her face. She told me she had never menstruated, and that she experienced a considerable amount of sexual excitement during coitus. On making a vaginal examination, I found the canal not more than $1\frac{1}{2}$ inches in depth, mons veneris covered with hair. The clitoris was about one inch long, with a complete prepuce, and the meatus urinarius opened about $\frac{1}{4}$ inch below it. The mucous membrane lining the vaginal orifice was of a peculiar dark red, with com-

plete absence of the labia minora. On either side of the mons, two almond shaped bodies were to be felt, tender to the touch, easily moved about towards the external abdominal ring, with a round cord attached to their upper ends. These bodies, from their size and shape, resembled more the testicle than ovaries. Through this short vaginal canal I could not detect any uterine body, and on a careful examination per rectum, I satisfied myself that this body was absent. By bimanual examination I could meet my two hands. Firm pressure above the pubis, and the finger in the rectum proved to me that no uterus existed, and retaining one finger in the rectum, and a sound in the bladder, I could bring them together easily, proving the non-existence of the uterus. This patient has been for some five or six years taking medicines for the purpose of bringing on menstruation, without having undergone any examination to determine the cause of the absence of this function. Complete absence of the uterus is not a common malformation.

THE EXCLUSION OF STRYCHNIA AND ARSENIC FROM ALL PREPARATIONS NOW IN COMMON USE.

BY GEO. PRINGLE, M.D., C.M., CORNWALL, ONT.

That strychnia is an invaluable remedy is unquestionable; that it is the cause of serious mischief in some cases, even where every precaution has been taken and every fact that could decide for or against its use been most carefully gleaned, is equally unquestionable. Having prescribed it during many years under most guarded rules for female patients, both married and unmarried, with good results, I have lately met with three or four cases the peculiarities of which I think well to bring before the profession, not so much for any practical lesson they teach as the moral they especially point, convinced that our failures, as we must have them, if properly noted, teach us more valuable lessons than our successes.

As the symptoms which indicated the employment of chalybeates with strychnia were much the same in all, I will not take up your space by describing more than one, but will give the result of the treatment in each.

CASE I. Mrs. J. K., æt. 30, mother of three children, consulted me in Jan. 25, 1883. She was of slight figure, complained of headache, vertigo, failure of sight, ringing noise in the ears, unpleasant taste in mouth and throat (especially in the morning), palpitation on the slightest exertion, poor appetite, bowels constipated, in short, functional derangement of every organ, but no disease, merely prostration. She was still nursing her fourth child, then fourteen months old; was perfectly sure she was not again pregnant; never had a return of menses since the conception of her first child, and never felt any of the unpleasant symptoms of pregnancy, but knew when she was so, as her children began to fail. The difference in the ages of the children ranged from twenty-two months to two years. Finding nothing pointing to pregnancy, I at once put her upon the following mixture:—

R—Tr. calomb.,	
Tr. rhei co.,	aa ʒj.
Acid nit.-mur. dil.,	ʒiv.
Liq. strych., B.P.,	ʒj.
Elix. iron et gent.,	ʒj.
Aqua ad.,	ʒiv.—M.

SIG.—One teaspoonful in water after each meal.

Ordered a podophyllin pill twice a week at bed time; also the immediate weaning of child, and to report the result of treatment in about two weeks.

CASE II. Was nursing her first child, then four months old, child large for its age; had no return of menses. I prescribed the following:—

R—Elix. iron, calisaya et strych.,	ʒiv.—M.
SIG.—One teaspoonful after each meal.	

Advised weaning the child, and rest as adjuvants; cautioned her as to the mixture and asked to know the result in about two weeks.

CASE III. Was the mother of three children; was nursing the third then four months old; her menses had not returned and did not usually do so until her children were ten months or a year old. There were no signs of pregnancy. I prescribed the same as for Case 2 and asked to hear result.

CASE IV. Was similar to Case 1, only I was more particular in my questioning if possible. The principle of treatment was the same as before, with a request to hear the result.

Now as to the result. In three cases out of the four the result was an abortion. Case 2 complained of most severe bearing-down pains, as in labor, and

painful micturition. Of her own motion she stopped the mixture for a time, the painful symptoms at once ceased, but upon again renewing her treatment they began to return, when she stopped it entirely. I then gave her a tonic, without strychnia, which benefited her at once. Case 1 had an abortion, but not for some time (about two weeks) after finishing her mixture. Case 3, whose infant was only four months old, had an abortion very soon after commencing her tonic. She stopped it while ill, began it after recovery, with no other ill results. Case 4, to her astonishment, also suffered an abortion, the first one in her life.

REMARKS.—Now admitting, for the sake of argument, that there are many causes, over which patients have no control, quite sufficient to produce abortion; admitting also that these three cases may have been merely accidental, they are very unpleasant, not to say dangerous, and as I do not care to run any more risk of such occurrences, I have therefore ceased prescribing strychnia for any patient where conception has taken place.

The moral pointed is this: In nearly every tonic elixir, strychnia forms an ingredient, and amongst the laity many do their own prescribing where a tonic only is needed, although the principle is a bad one. When one reflects, therefore, that these elixirs are often prescribed in this way, many of them containing not only strychnia but arsenic, he cannot but ask himself the question, if so much mischief may be done quite unintentionally in such cases as mentioned, how much more may be done designedly?

I would suggest that, if it be possible, the profession should unite in urging upon manufacturers the propriety of excluding both strychnia and arsenic from all elixirs and leaving these two dangerous remedies solely in the hands of physicians.

Reports of Societies.

CANADA MEDICAL ASSOCIATION.

The seventeenth annual meeting of the Canada Medical Association was held in Montreal on the 25th, 26th and 27th August. There was a large attendance of members from all parts of the Dominion.

The President, Dr. Sullivan of Kingston, took the chair at 10.30 a.m., and Dr. Hingston, chairman of the Local Committee of Arrangements, welcomed

the members on behalf of the profession of the city of Montreal. Mr. Lawson Tait of Birmingham, Drs. McGraw and Brodie of Detroit, Dr. Murphy of Kansas, and Dr. McMillan of Hull, Eng., together with the past Presidents, were invited on the platform.

The minutes of the last meeting were read and approved. A large number of new members were proposed and elected.

Dr. Fulton read the report on Necrology, giving the names of members who had died during the year.

The Secretary read the report on public health by Dr. Canniff, and it was referred to the proper Committee.

The following officers of sections were nominated by the President, viz: *Medical Section*—Chairman, Dr. Thorburn, Toronto; Secretary, Dr. Burt, Paris. *Surgical Section*—Chairman, Dr. Roddick, Montreal; Secretary, Dr. Tye, Chatham. The meeting then adjourned.

The association again met at 2.30 p.m. The President read his address, of which the following is a brief abstract, after which the meeting resolved itself into sections:

After an introduction in which he referred to the manner in which the Association had been established immediately after confederation, and to the great good that resulted from these friendly meetings, he referred to the varying death rate in the Dominion as revealed by the last published volume of the census. In Ontario the death rate was 11.81 per 1,000, in British Columbia, 20.38, in Quebec, 19.07. Thus, Ontario, with a population 600,000 greater than Quebec, had actually 3,000 less deaths per annum, the figures being, Quebec, 25,930; Ontario, 22,727. This was due he found to the great mortality among children in this Province, the number of deaths from 1 to 11 years being more than sufficient to account for the difference. The figures show that in the Province of Quebec children between the above ages to the number of 16,142 die, a majority of 1,973 being boys, while in Ontario the number is 10,471, with a majority of 973 boys, the difference in favor of Ontario being 5,671.

Each child was valued at \$40 to the state by good authority, thus a heavy infantile death rate was an enormous loss, and it could be greatly reduced, as the diseases most fatal, such as small-pox, measles, scarlet fever, typhoid and typhus fevers, could be prevented or confined within narrow limits by proper precautions.

The importance of a bureau of vital statistics was also touched on. There were 3,567 physicians

in the Dominion, with about 800 students; while in the United States about 4,000 physicians were produced a year, and there were 90,000 doctors. He claimed that the average standard of the profession in Canada was equal to any in the world. The necessity of a high standard for students, so that uneducated men could be kept out of the profession, was pointed out. With regard to female medical education, Dr. Sullivan spoke in rather jocular, but at the same time friendly terms, declaring his belief that the presence of women in the profession would raise the standard, not lower it. With regard to the subject of medical service upon ocean steamers, if it was true that the British Act required that the surgeons be shipped only in Europe, then they should get the Act amended, as Canadians ought to have some of these appointments. Great need for reform was said to exist, and a bill was now before the American Congress requiring an extra physician on all ships carrying 600 people beside the crew. Nurses and hospitals were also demanded, and as the mortality was as high as 70.6 per 1,000, there appeared to be good grounds for such demands. Allusion was made to the researches now going on in regard to disease and to the germ theories, and particularly to the announcement that "the dread scourge cholera" was the result of a microbe, also to the inoculation for yellow fever, by Pasteur's method, which had been followed in Brazil with such good results that out of 450 foreigners inoculated with it, less than two per cent. died, while among the uninoculated the death rate was 30 or 40 per cent. He closed by referring to the fact that medicine was every year being held in higher estimation, and it was the duty of all medical men by deep study and research to keep up the standard of the profession. He also referred to the grand opportunity they would enjoy owing to the presence of the British Association in the city.

MEDICAL SECTION.

The first paper on the programme was "Puerperal Septicæmia," by Dr. Campbell, of Seaforth.

Dr. Sheard asked if Dr. Campbell had made any pathological investigations. He said cases occurred where the autopsy showed no lesions of the uterine tract.

Dr. A. Wright asked if the writer had discovered any other causes aside from laceration. He did not think it could be shown that the lacerations were the cause of the absorption.

Dr. Smith alluded to the identity of this disease with surgical fever, and advised disinfection of the hands and other antiseptic precautions.

Dr. Brodie (Detroit) thought in many cases he could predict before confinement that puerperal fever would follow. There was in some cases an erysipelatous element before birth.

Dr. Patterson thought puerperal fever and sep-

ticæmia were identical. It arises occasionally from atmospheric causes, without any other known source.

Dr. Mullin said that in the majority of cases he thought it due to decomposition of clots or shreds within the uterus. He did not think erysipelas was the potent cause it is sometimes represented to be.

Dr. McKay thought the poison might be generated in a debilitated system through imperfect resolution.

Dr. Campbell, in reply, thought the poison in his case originated entirely within—autogenetic.

The Chairman remarked upon the close alliance of erysipelas and puerperal fever.

Dr. Dupuis read a paper on "Nostrums and Medical Advertising."

Dr. Bray referred to the efforts that the Medical Council in Ontario had already put forth, and he hoped that the Councils in both Ontario and Quebec would be supported by the general profession.

Dr. Day said they were going to the Legislature to obtain power to strike from the register any member who should demean himself by unprofessional conduct.

In the Evening Session, Dr. R. MacDonnell exhibited two cases of "Lateral Sclerosis."

Dr. Osler remarked upon the probability of local focus being present in nearly all cases. He described cases of difficulty of diagnosis from caries of vertebræ.

Dr. Harrison of Selkirk read a paper on "Cerebro-Spinal Meningitis," describing several cases which had occurred in his neighborhood. He had alluded to a peculiar form of fever in a paper before this Association two years ago. He now considered that they properly belonged to the category of cerebro-spinal fever. The disease had occurred both in children and in adults.

Dr. R. P. Howard said the disease was rare in this country. In some few localities, as Sarnia, for instance, it is often seen. Its true pathology, and the explanation of these outbreaks would be interesting.

Dr. Bray had seen one epidemic of this fever in his district. The poor, and more particularly colored people were attacked. It was very fatal.

Dr. Geo. Ross took exception to arguments concerning the nature of the disease described, unless substantiated by *post-mortem* examinations. Tubercular disease of the nervous centres will often perfectly resemble the genuine cerebro-spinal fever.

In reply, Dr. Harrison said he treated his cases with bromide and iodide of potassium. The cases he had been describing occurred within a radius of six miles; the shortest lasted four weeks, the longest from 10 to 12 weeks. There was not always hyperæsthesia.

Dr. F. W. Campbell said the cases he saw in the epidemic 10 years ago were amongst the well-to-do.

Opisthotonos was generally present, then remittent and intermittent types of fever. Large doses of quinine did harm.

Dr. Osler said that the diagnosis of cerebro-spinal meningitis must be received with great caution. Of four cases submitted to him for *post mortem* examination only one showed a true inflammation of the meninges.

Dr. Mullin said that the cases observed in Hamilton occurred within four months. Isolated cases seen since were probably typhoid.

Dr. Lett, of Guelph, read a paper on "The Opium Habit and its Treatment," describing its ill results and the treatment which he found most beneficial.

Dr. Pickup enquired as to the value of coca leaves in the treatment. Dr. Lett replied that no substitute or antidote could be considered reliable.

Dr. H. Howard said that he never saw an opium-eater who had not been previously a drinker. He recommended gradual diminution of the dose of opium together with supporting treatment.

Dr. R. P. Howard next read a paper on "Some Varieties of Dyspnoea met with in Bright's Disease," referring especially to Cheyne-Stokes' respiration.

Dr. Geo. Ross described two cases bearing upon the case. The first was an elderly gentleman, suffering from spasmodic asthma. Examination of the urine showed the existence of Bright's disease. Subsequently there was typical Cheyne-Stokes' breathing, which continued during three or four months. The second case was a lady who had long suffered from asthma, but its dependence on Bright's disease was overlooked. A peculiar feature of her case was the sudden development, during these attacks, of pulmonary congestion, as shown by universal rales and bright blood in the sputa.

Dr. Osler referred to Cheyne-Stokes' breathing in a little girl one year old. He examined the urine, but found nothing. It passed off, and the child is now in its usual health.

Dr. Howard had never observed congestive symptoms. He also suggested that the child mentioned by Dr. Osler should be watched still, as the disease may develop. Frequent examination of the urine was absolutely necessary to make a real diagnosis. As regards treatment, he limited himself to treating the disease itself, as usual, with diaphoretics, vapor baths, etc. Sometimes nitroglycerine was useful.

Dr. W. Gardner, of Montreal, then read a paper on "Common Errors in Gynæcological Practice." He stated that the slighter forms of pelvic peritonitis and cellulitis were often not recognized. In regard to pessaries much misconception obtained. Some practitioners had unbounded faith in them, while others, of equally small experience, decried them as of little or no value. He thought that while pessaries and other therapeutic agents were

often of the greatest value in the treatment of displacements, such affections when chronic, were rarely completely cured. Constitutional treatment in addition to appropriate local treatment was often overlooked.

Dr. Trenholme did not agree in regard to the great frequency of chronic pelvic inflammations or their influence on uterine affections. He also approved of the use of pessaries in displacements.

Dr. Heywood Smith, of London, Eng., endorsed most of the author's view, but believed that perimetric hæmatocele was the starting point of many cases of pelvic inflammation.

In reply to Dr. Brown, of Acton Vale, Que., Dr. Gardner said that he believed in the efficacy of hot water vaginal douches in the treatment of chronic pelvic inflammations.

Dr. H. Howard read a paper entitled "Materia Cogitans," giving his views on the relation between thought and brain-matter, after which the section adjourned.

SURGICAL SECTION.

The first paper was presented by Dr. Blackader, on "Case of Congenital Lipoma of the Foot." The enlargement which was noticed at birth, had increased in spite of continual elastic pressure by Martin's bandage. At the age of fourteen months the hypertrophied toes and tumor were removed by Dr. Roddick, and the wound healed kindly. Reference was made to the history of similar cases, their etiology and pathology, and to the views of Dr. Busey, of Washington, who referred the changes to congenital defect or disease of the lymphatic system.

Dr. Osler referred to a case in which there was congenital and progressive enlargement of the right upper extremity, the bones, muscles, etc., all being enlarged. In this case the palm of the hand was especially enlarged, owing to an increase in the amount of fat.

Dr. McGraw, of Detroit, mentioned a case which he had seen in Langenbeck's clinic in 1861, where there was enlargement of the left lower extremity and left side of pelvis. There was simple hypertrophy, uncomplicated with any tumor, involving all the tissues of the limb, which became so large that the girl was unable to walk.

Dr. Fulton, of Toronto, then read his paper on the "Thoraco-plastic Operation of Estlander." This paper will be published in a future number of the LANCET.

Dr. Hingson thought the question of operating in empyema a difficult one, for we seldom find two cases exactly alike. Estlander's operation would be more successful if portions of more ribs, but to a less extent, were excised. He recommended the thorough washing out of the chest with carbolic lotion and the free exposure of the whole surface as the best methods of treatment.

Dr. Kerr gave an account of a case which he had seen in consultation, which might be benefited by this operation. A free incision had been made, the patient sent to the sea-side and the general health attended to, and the discharge had diminished. He thought the curette might be used for the eradication of the pyogenic membrane.

Dr. Holmes thought that if cases of empyema were treated earlier, less disastrous results might ensue. Slow closure is often due to the fact that pus has remained in the cavity a long time, and by its presence interfered with the vitality or tone of the membrane.

Dr. Roddick alluded to the various methods of treating empyema in the Montreal General Hospital. In chronic cases the rule now is to excise an inch or more of one rib, if necessary, and drain by means of a tube of large calibre, antiseptic precautions being taken throughout.

Dr. Sherrieff, of Huntingdon, then read a paper on "Hæmorrhoids," in which he had pursued with success the treatment of crushing, as advised by Pollock in Braithwaite for January, 1883, and as carried out by him in his wards at St. George's Hospital, London.

Drs. Sloane, Hingston, Tye and Roddick made remarks upon the paper.

In the evening session, Dr. Fenwick, of Montreal, read a paper on "Abscess of Abdominal Parietes extending from Meckel's Diverticulum," from which a large concretion escaped, composed of fæces incrustated with phosphate of lime.

Dr. R. P. Howard referred to a case he had recently seen, of acute inflammation and suppuration about the umbilical region; poultices were applied and in a few days a semi-solid concretion about the size of a bean escaped, and the patient said that five such had been passed. The patient recovered. Dr. Howard thought there was connection with the bowel, probably through the umbilical vesicle which had remained patulous.

Dr. King, of Hull, Eng., mentioned a species of abscess which began by a hard, deep swelling, situated so deeply that it was difficult to make out whether it was intra or extra-abdominal. They began in the muscles, sank towards the inguinal region and there appeared as carbuncular swellings.

Mr. Lawson Tait suggested that the calculus found by Dr. Fenwick should be cut, for he thought it was made up of cholesterin, and therefore hepatic in origin. He advised an immediate opening of the abdomen in all cases where the matter discharged from a sinus in the abdominal walls has a fæcal odor.

Dr. Shepherd, of Montreal, read a paper on "Ligature of Anterior Tibial Artery in a Case of Compound Fracture of the Leg," and showed the patient. Drs. Fenwick, Sullivan, Fulton, Giles, Girdwood, Holmes and Proudfoot took part in

the discussion, after which Dr. Gardiner, of London, Ont., read a paper on "Burns and their Results."

Dr. Stewart, of Montreal, then read an interesting paper on the "Action and Uses of Naphthalin." As an antiseptic it compares very favorably with iodoform. It is especially suitable in chronic ulcers and burns which have no tendency to heal. Iodoform is apt to induce a certain sponginess of a granulating surface, and after a certain stage in the treatment, does more harm than good. Naphthalin can be used throughout the treatment of a sore, and in place of retarding the healing after rendering the tissues antiseptic, it actually promotes it. It can be used either in a finely powdered form or in gauze.

Dr. Shepherd agreed with Dr. Stewart that iodoform was useless in granulating wounds; in such cases he used Balsam of Peru or naphthalin, but considered the balsam best as a stimulant.

Dr. Roddick used it in old burns and chronic ulcers with satisfaction, combined with boracic acid to facilitate the dusting of it. In empyema or large abscesses, he used naphthalized jute as an outside dressing.

Dr. Reeve, of Toronto, read a valuable paper on "Trephining the Mastoid" (fifty cases).

SECOND DAY.—GENERAL MEETING.

After the reading of the minutes, Dr. Mullin presented the report on Ethics, which was adopted.

The President then called upon Mr. Lawson Tait to deliver his address on "Abdominal Surgery," which will be found in this number.

MEDICAL SECTION.

Dr. Geo. Ross showed two specimens of Aneurism of the Thoracic Aorta, one obtained that day, the other two weeks previously. In one case, the physical sign of tracheal tugging had been present; in the other, absent. In both cases, this sign had been of great service in diagnosing the aneurism.

Dr. Worthington, of Clinton, read a paper on "Some cases of Diabetes Insipidus," one of which was complicated with exophthalmic goitre.

Dr. Harley, of London, made some remarks. He objected to the term Diabetes Insipidus, and preferred the term Polyuria. It may sometimes be connected with congestion of the kidneys, but is often present in chronic atrophy. In one of Dr. Worthington's cases twenty-five pints were passed in 24 hours. What is the exciting cause? Very often this cannot be traced. In saccharine diabetes, the sugar is the essence of the disease, and the quantity of water is only for the purpose of eliminating the sugar. The treatment of polyuria is very unsatisfactory. The only satisfactory management is the care of the patient's general hygiene.

Mr. Mills mentioned a case he had observed

under Dr. Stephen McKenzie. A lady had been in the habit of eating great quantities of sugar, which produced diabetes mellitus.

Dr. Sloane, of Blyth, instanced a case of polyuria where the amount of urine was very large and the specific gravity 1003. Iron was of no use. Bromide of potassium and ergot seemed to do good.

Dr. Sheard spoke of certain cases of diabetes mellitus, in which he had opportunities of examining the brain centres. Microscopical changes were found.

Dr. Geo. Ross said that Dr. G. Johnson, of London, had proved the existence of changed structure in the great semilunar ganglia of the sympathetic. He also referred to a case of polyuria in a woman, the subject of secondary cancer of the liver. He thought the co-existence of exophthalmic goitre of great interest in showing, in the same individual, disorder of another portion of the great sympathetic system.

Dr. T. Wesley Mills showed an improved method of making a quantitative test for sugar in the urine.

Dr. O. C. Brown, of Acton Vale, read a paper on "Impaction of the Pregnant Uterus in the Pelvis as a Cause of Abortion," giving cases which had occurred in his practice and which he had successfully treated.

Dr. Playter read a paper on "The Relation of the Medical Profession to the Public."

Dr. Gurd showed a patient in whom a cardiac murmur could be heard in the mouth and at a short distance from it, transmitted from the chest. The murmur was mitral systolic.

SURGICAL SECTION.

This section met at 3.30 p.m. Dr. Major, of Montreal, read a paper on "Buccal Breathing."

Dr. Elsberg, of New York, made a few remarks in support of the views held by Dr. Major.

Dr. Proudfoot, of Montreal, read a paper on "Paracentesis of the Membrani Tympani."

Dr. Reed, of Montreal, exhibited an interesting case of "Inguinal Hernia." The scrotum was of immense size. The hernia occurred twelve years ago, and is now irreducible.

Dr. Sutherland showed a case of "Keloid." The patches were situated on the chest, right gluteal region, and right shoulder.

Dr. Oldright, of Toronto, read a paper on "Myxo-Sarcoma," a sequel to the paper read last year.

Dr. Shepherd, of Montreal, read a paper on "An obscure case of Femoro-Popliteal Aneurism," in which amputation was performed, and showed the specimen.

Dr. Gardner, of Montreal, read a paper on "Uterine Myoma." He had operated successfully on four cases.

Dr. Strange, of Toronto, said that he never incised the cervix, but trusted to slow and gradual dilatation. He used free irrigation of the uterus after operating to wash away the debris.

Dr. Heywood Smith, of London, Eng., thought such method of operating was not applicable in all cases, especially in nulliparous women, in whom the parts are of necessity small. He thought that any incision made in the cervix should be allowed to heal before proceeding to operate.

Dr. Buller, of Montreal, read an interesting paper on "Jequirity in Granular Ophthalmia," and exhibited a rabbit on which he had been experimenting with this remedy. Dr. Reeve, of Toronto, gave his experience of its use.

Dr. Elsberg exhibited a new and improved forceps for removing foreign bodies from the throat.

Dr. Osler gave an abstract of his paper on "Pneumonia as a Contagious Disease."

The following officers were elected for the ensuing year:—*President*, Dr. Osler, Montreal; *General Secretary*, Dr. James Stewart, Montreal; *Treasurer*, Dr. Sheard, Toronto; *Vice-Presidents*, Ontario, Dr. Bray, Chatham; Quebec, Dr. Geo. Ross, Montreal; New Brunswick, Dr. Allison, St. John; Nova Scotia, Dr. Fraser, Windsor; Manitoba, Dr. Whiteford, Winnipeg; *Local Secretaries*, Ontario, Dr. Burt, Paris; Quebec, Dr. J. Bell, Montreal; New Brunswick, Dr. Walker, St. John; Nova Scotia, Dr. Almon, Jr., Halifax; Manitoba, Dr. Mewburn, Winnipeg.

COMMITTEES.—*Publication*, Drs. Kennedy, Montreal; Fulton, Toronto; W. H. B. Aikins, Toronto. *Medicine*—Drs. Cameron, Toronto; F. W. Campbell, Montreal; Saunders, Kingston. *Surgery*—Drs. Kerr, Winnipeg; Kains, St. Thomas; Waugh, London. *Obstetrics*—Drs. Holmes, Chatham; McKay, Woodstock; Campbell, Seaforth. *Therapeutics*—Drs. Oliver, Kingston; Sloane, Blyth; Tye, Chatham. *Necrology*—Drs. Fulton, Toronto; Graham, Toronto; Cameron, Montreal. *Education*—Drs. Pyne, Sheard and A. H. Wright, Toronto; Botsford and Allison, St. John; Arnott, London. *Public Health*—Drs. Yeomans, Mount Forest; Grant, Ottawa; Harding, St. John; Robillard, Ottawa; Larocque, Montreal; Botsford, St. John; Playter, Ottawa; Drs. Bryce, Covernton and Oldright, Toronto; Hon. Dr. Parker, Halifax; Kittson, Winnipeg. *Arrangements*—Drs. Ferguson, Kerr, Whiteford, Mewburn, Patterson, O'Donnell, Codd, Lynch, and Jones, with power to add to their number.

After formal votes of thanks to officers of the Association and others, the Association adjourned to meet in Winnipeg on or about the third Tuesday in August, 1885.

BRANT COUNTY MEDICAL ASSOCIATION.

The Annual Meeting of the Brant County Medical Association was held in Brantford, on Tuesday,

2nd September. The minutes of last meeting were read and confirmed. Dr. Winskell read an interesting paper on "Uræmic Convulsions," which was well received and discussed.

This being the Annual Meeting, the election of officers took place for the ensuing year, and resulted as follows, viz.: Dr. Marquis, Mount Pleasant, President; Dr. Winskell, Brantford, Vice-President; Dr. Fairchild, Mount Vernon, Secretary-Treasurer.

The term of office of Dr. McCargow, the representative of the Erie and Niagara division in the Ontario Medical Council having nearly expired, Dr. Henwood, the former representative, paid a just tribute to the zeal with which Dr. McCargow had performed his duties while a member of the Council.

It was then moved that Dr. Philip, of Brantford, be the nominee of the Brant Medical Association as the representative of the division in the Ontario Medical Council, which was carried unanimously. In accepting the nomination, Dr. Philip paid a high tribute to the ability of those who had represented the division in the Ontario Council since its inauguration. He dwelt upon several matters which would come before the Council, and said that whether he was elected or not, he should ever feel grateful to his medical brethren in the county of Brant for the confidence reposed in him.

Dr. A. J. Henwood was elected a member of the Association. Dr. Burt, of Paris, was appointed to read a paper at the next meeting, which will be held in Brantford in December. After some routine matters were disposed of, the Association adjourned.

Selected Articles.

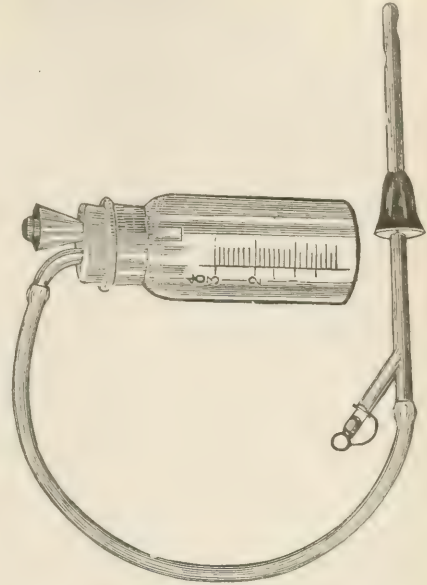
APPARATUS FOR ETHERIZATION BY THE RECTUM.

Dr. J. S. Miller of Philadelphia read a paper before the County Medical Society (*Medical News*) in which he reported four cases of etherization by the rectum, and exhibited a form of apparatus shown in the cut. It consists simply of a water-bath, a graduated bottle provided with a funnel and valve for pouring in the ether, and a supply-pipe for conducting the vapor to the rectum. This tube terminates in a straight recurrent catheter, the exhaust channel of which is controlled by a valve. The catheter is furthermore provided with a movable collar for pressure against the anus—it having been found that the vapor tends to escape by the side of the tube.

Some question having arisen as to whether the vapor really does pass the ileo-cæcal valve, I deemed this a subject for legitimate vivisection, and, etherizing a cat per rectum, opened the ab-

dominal cavity, and noted that the small intestine was as greatly distended as the large.

In this method of etherization, the most obvious advantages are as follows:



1. Dyspnoea is avoided, and the patient is saved from the anxiety due to a sense of impending suffocation.

2. There is avoided the danger of simultaneous irritation of the superior laryngeal and pneumogastric nerves at the periphery—these irritations neutralizing each other in the respiratory centre, and suspending respiration entirely.

3. The danger of asphyxia is lessened—the patient not being drowned in his own mucus, and the integrity of the pulmonary mucous membrane as an organ of gas exchange is preserved. Of course, some vapor finds itself in the lungs, and acts there as a local irritant—elimination being by that channel. But the quantity is not great, and does not constitute a source of danger. In the cases reported, the increase in secretion was too trifling for discovery.

4. The stage of excitation is therefore not prolonged by the struggles for breath. In general, it may be said that the delirium of any alcoholic intoxication is a pleasant and good-natured one, unless the patient is crossed—as he certainly feels himself to be when a wet towel is pressed over his face.

5. Nourishment may be taken before operation to sustain the powers of life, and lessen the dangers from shock.

6. Return to consciousness is prompt—this stage not being prolonged by carbonic acid poisoning.

7. The anæsthetic seems as readily suspended as by the ordinary method—the bowel being promptly emptied by gentle massage.

8. Economy in ether is an advantage hardly to be mentioned with more important considerations.

The more obvious disadvantages are :

1. The exposure of person required—the abdomen being necessarily under observation, even if the catheter be inserted under cover.

2. More judgment and experience are required in the administration, than by the ordinary method—over-boiling in the apparatus, and too much distention, being both painful and highly dangerous. The warning to cease is sudden, and must be immediately obeyed.

3. Just as the other mode is inconvenient in oral surgery, so in perineal operations is the apparatus needed for this method, in the way.

4. In abdominal surgery, or if there be marked intestinal lesion, this mode is contra-indicated.

5. The inapplicability in cases of accident and emergency, when time cannot be allowed to prepare the bowel, has already been mentioned.

6. Diarrhoea has been noted in seven out of the thirty-seven cases on record, though in none of mine.

I believe this sequel is due to pre-existing intestinal lesion, to the lack of preparation, to a too great distention of the bowel, or to the accidental introduction of ether in liquid form. Furthermore, my method has differed from that of other experimenters in this respect, that instead of allowing the vapor to remain indefinitely, I secured a constant change by using a recurrent catheter, and introducing a certain quantity, or permitting it to escape, as indicated.

Other points of advantage and disadvantage may occur in later experience, and to other observers, and new dangers may be discovered. But I am convinced that this method is worthy of further trial, and will find its place in surgery, fulfilling its own, though not *all*, indications. Like all else in therapeutics, it must pass through the stages of bungling use, condemnation, and revival.

PYO-SALPINX AND HYDRO-SALPINX.

Dr. Wm. Goodell exhibited specimens of the above at the Obstetrical Society of Philadelphia, June 6th, 1884

In the former case the lady was unmarried, and had suffered from pelvic pains and menorrhagia for several years. Last autumn a tumor was discovered by her physician, who deemed it a fibroid of the womb. Early this year her sufferings became so great that she took to her bed. Very large doses of morphia were needed, and septic symptoms now set in. After she had been in bed for several weeks, Dr. Goodell was called in to see her. The tenderness of the abdomen was so great that the examination was made under ether. Even then the diagnosis was obscure because she flinched and

her recti muscles became tense whenever the abdominal wall was pressed upon. A cyst was discovered, but of what nature it was impossible to determine. Dr. Goodell operated on her at his private hospital. The womb was studded with small fibroid nodules, posteriorly it had an outgrowth as large as a small egg. Closely adherent to the womb, to the pelvic fascia and to the intestines, was a thick-walled cyst of the left ovary, as large as the largest orange. The corresponding oviduct was very thick and enlarged to the size of a small sausage. It and the cyst were filled with a very dark purulent fluid, although there was no communication between them. The lower end of the cyst had become necrosed, and was so thinned out that it would very soon have given way at that point. On account of the presence of fibroids in the womb, the right ovary was also removed. Attached to the fimbriæ of the oviduct were three very beautiful pedunculated vesicles ; while two others not yet pedunculated lay in the stroma of the broad ligament. The recovery of the lady was uninterrupted.

In the case of hydro-salpinx, the patient was a widow aged 37, who had been sent to him in order to have her ovaries removed. Severe pains began a week before the menstrual flow, culminating during the flow and continuing one week longer, then fading gradually away. For three weeks out of every month she was confined more or less to the recumbent posture, and wholly so during the menstrual week. A tear of the cervix and one of the perinæum had been well repaired by two surgeons, but with no improvement. Dr. Goodell wished her at first to try the rest treatment with massage, electricity and graded muscular movements, for he had repeatedly cured cases of this kind through such a mode of treatment. She was, however, too poor to take this treatment privately, and was therefore urgent to have her ovaries removed. The operation was performed fifteen days ago, and she is now doing very well indeed. The ovaries as exhibited were much enlarged, and showed marked follicular degeneration. From this condition Dr. Goodell thought that nothing short of the operation would have cured her. Attached to one oviduct was a delicate vesicle with a thread-like stem of over an inch in length. In view of the frequency with which they are found, he could not but think that these vesicles played some role in the economy, and that they had sometimes a pathological bearing. He had on several occasions met with small post-uterine cysts which burst either spontaneously or under the pressure of an ordinary vaginal examination. Taking advantage of this fact, he had quite recently burst one designedly by bi-manual pressure. Such delicate cysts, and also those very movable ones which remained small without increase in bulk, he was disposed to attribute to these vesicles. After bursting

these cysts sometimes refill. One he had known to burst and refill at least six times before it disappeared. New small ovarian cysts had, in his experience, thick walls, and, further, they rarely remain small any length of time. Dermoid cysts, on the other hand, often remain stationary for years, but they were generally not very movable, and they also had thick walls.

Dr. Albert H. Smith had found these cases of pyosalpinx very difficult of diagnosis. He had been present at an operation by Knowsley Thornton upon a case in which the lesion was double and both tubes and ovaries were removed. Rupture had occurred previously, and had been followed by peritonitis. The patient recovered.

Dr. B. F. Baer inquired if Dr. Goodell would recommend rupture of cysts arising from the carotids of morgagni.

Dr. Goodell would consider it good service for the purpose of preventing the further growth of the cyst. He had always found the fluid in such cases to be unirritating.

Dr. Albert H. Smith remarked that Schroeder holds that the fluid of an ovarian cyst is not noxious to the peritonæum. He makes no effort to secure the peritoneal cavity from its ingress during the operation, and yet his statistics show at least fair success.

In response to a question by Dr. C. Meigs Wilson, Dr. Goodell stated that the dressing of the wound after the operation was glycerole of carbolic acid with the Lister gauze.

Dr. Goodell also gave the following history of a case of hysterectomy. The woman was unmarried, aged 47. Her monthly fluxes began to be free in 1867. A year ago they became so exhausting that she could not pursue her trade as a seamstress. On April 30 she consulted Dr. Goodell, who found the whole abdomen filled with multiple fibroids of the womb. The cervix had disappeared and the os uteri lay so high up that it was not possible to introduce the sound. The operation was performed at the Hospital of the University of Pennsylvania, on May 22, on the same day with the preceding case. One outgrowth as large as the two fists contained a cavity filled with cheesy matter, and was so adherent to the abdominal wall and intestines as to need the knife for its release. It was possibly the right ovary, but he was by no means certain. Koeberle's wire-clamp was passed around what corresponded to the neck of the womb, but it was as large as his arm above the elbow. The woman's recovery thus far has been uninterrupted. The temperature reached 100° but once. The clamp fell off on the 16th day, leaving a very deep funnel-shaped pit. He had intended to exhibit the specimen, but it was too bulky to carry and also had become quite offensive. In this case had he been able to reach the ovaries or to have discovered them he would have removed them in prefer-

ence to performing hysterectomy; but the firm adhesions prevented the rotation or the lifting up of the tumor, hence the ovaries were inaccessible. Sometimes even when the uterine fibroid can be lifted out of the wound and the ovaries reached, these organs are so embedded in the fibroid, or so drawn out in ribbon-form on the surface of the tumor as to make their complete removal impossible. When, however, the ovaries can be removed with safety, the operation is a most promising one, as he could attest from several most successful cases.

DIAGNOSTIC SYMPTOMS IN THE DISEASES OF CHILDREN.—Politzer gives the following concerning the value of certain symptoms in children's diseases (*Deutsche Med. Zeitung*, May 19, 1884): 1. The symptom of a strongly-marked nasal tone in crying points to the probable existence of a retro-pharyngeal abscess. 2. A loud and very long-continued expiratory sound, with normal inspiration and the absence of dyspnoea, is significant of chorea major. Sometimes this sound resembles the bellowing of an animal, and may continue for a long time as the only symptom of chorea. 3. A thoracic, sighing inspiration indicates cardiac weakness. This is one of the first symptoms, appearing before cyanosis or pallor of the face, thready pulse, coldness of the extremities, or the other well-recognized signs of weak heart. 4. A marked diaphragmatic expiration, accompanied with a fine, high-pitched whistling, points to bronchial asthma. 5. A marked interval between the end of expiration, and the beginning of inspiration renders the diagnosis of catarrhal laryngitis without exudation probable. 6. There is no special significance in the loud, sort of bleating expiratory sound sometimes observed in infants during the first months of life. It seems to depend upon a modified innervation within physiological limits, and resembles the want of rhythm in the cardiac movements occasionally met with in the early years of childhood.

The following symptoms are indications of cerebral diseases: 1. A peculiar drowsiness, continuing for several days, unaccompanied by fever or other disturbance, is indicative of basilar meningitis. This is a more valuable sign than headache, vomiting, or a slow, irregular pulse, since the latter may occur in various extracranial diseases. 2. A tense, elevated anterior fontanelle points to intracranial effusion. If it be very prominent, resistant to pressure, and without a sign of pulsation, there is almost certainly an intermeningeal hemorrhage. A deeply-sunken fontanelle indicates inanition and a diminished volume of blood. 3. Very slow movements of the eyes, followed by fixity in one position, a vacant stare, and a peculiar lazy closing of the lids are signs of a beginning basilar meningitis. The character of the cry is of value sometimes in the diagnosis. 1. A fit of shrill crying, lasting for

two or three minutes, accompanied by an expression of fear in the face, and coming on regularly an hour or an hour and a half after the child has gone to sleep, is the expression of night-terrors. Quinine, given in a rather large dose one or two hours before bed-time, is an effectual remedy against this trouble. 2. Periodical crying-spells, of five or ten minutes' duration, coming on sometimes during the day but more frequently only at night, point to cramps in the bladder, provided that we can exclude intestinal or gastric colic. This is speedily cured by emulsion of lycopodium with or without belladonna. 3. Crying while at stool and an evident dread of the act of defecation are signs pointing to fissure of the anus. 4. Hard, continuous crying, expressive of severe pain, together with frequent putting of the hands to the head or rolling of the head in the pillow, are evidences of otitis media or pain in the ear from some other cause. 5. When for days and weeks the child cries on being moved, and when there is also profuse sweating and an elevated temperature, the disease is rickets. 6. Frequent crying, with habitual sleeplessness during the first two years of life, are found in anæmic and poorly-nourished children, or in those with congenital syphilis. He also recounts some other single symptoms which aid in diagnosis. 1. The peculiar physiognomy of children suffering from congenital syphilis. The sinking in of the root of the nose, the sallow complexion, the scanty eyelashes, the yellowish edges of the eyelids, and the rhagades on the underlip are characteristic of hereditary syphilis. 2. A falling together of the alæ nasi, and an absence of all motion in them during inspiration, point to hypertrophy of the tonsils. 3. A weakness and loss of motion out of all proportion to the gravity or duration of the accompanying illness should raise a suspicion of infantile paralysis. 4. A partial loss of hearing after a sickness is often due to a circumscribed meningitis at the base of the fourth ventricle. 5. Depression of the mental faculties occurring after a severe infectious disease is frequently indicative of a beginning acquired idiocy. Strychnine exerts a favorable influence in these cases. 6. Retarded ossification of the skull may imply rachitis. 7. A stiff carriage of children in walking, standing, sitting down, or stooping, is observed in commencing Pott's disease. In children who do not walk there is a painful contraction of the features when they are lifted up or set down. 8. Constant vomiting of all ingesta, lasting for several weeks, in children with large heads but closed fontanelles, is a sign that an acute hydrocephalus is engrafted upon the chronic condition.

HODGKIN'S DISEASE AND INTERSTITIAL HEPATITIS.—Prof. Da Costa has under his care a patient who has had Hodgkin's disease for fifteen years. The disease has been kept in check by living in a

yacht, supplementary to treatment. He strongly urges arsenic, increased in dose until constitutional symptoms are manifested, and kept there, as the best medicinal treatment.

Prof. Da Costa also teaches that in the early stages (before contraction) of interstitial hepatitis (cirrhosis), a cure may be effected, but that after contraction nobody ever recovered. He has seen the disease in women who did not drink, and the worst case he ever had was in a boy four years old, in which the diagnosis was confirmed at the autopsy. Inherited syphilis is a cause of it. In the early stages the remedies are leeches, sulphate of magnesium, cream of tartar, iodide of potassium. —*Col. and Clin. Record.*

NEW OPERATION FOR CANCER OF THE RECTUM.—At a meeting of the Société de Médecine of Lyons in May, (*Courier of Medicine*) M. Maurice Pollosson read a paper in which he proposed a modification of the operations hitherto practised for the relief or cure of cancer of the rectum. The establishment of an artificial anus as a palliative measure has long been recommended and practised. By this means the irritant effect of the fecal matter upon the cancerous mass is prevented; the patient is relieved from much suffering, and the cancerous mass being freed from irritation, grows less rapidly.

M. Pollosson adopts this procedure in a modified form as a preliminary step in his plan for radical treatment of this affection. He selects the left iliac region as the site for the operation, because there more readily than in the lumbar region can he close up the lower segment of the bowel, which he regards as a point of essential importance in the operation. This he does by invaginating some millimetres of the lower free end, after dividing the bowel clean across, and obliterating the opening completely by means of five or six cat-gut sutures which thus bring into close apposition the serous surfaces. The artificial anus is completed by suturing it carefully into the wound.

After the patient has recovered from this operation, he proposes to extirpate the cancerous mass which, by virtue of the preliminary operation, is practically removed from its relations as a part of the digestive tract and converted into a pelvic tumor. Operating under the conditions so brought about, it is possible to apply the principles of antiseptic surgery much more thoroughly and efficiently than in the condition existing without such a preliminary operation.

In most cases he believes that it would be advisable to allow the patient to recover from the effects of the first operation before performing the second, though he thinks that circumstances might be such as to make it better to go on at once and extirpate the cancerous mass at once after establishing the artificial anus.

EPILATION IN PARASITIC DISEASES.—Although this plan has the sanction of age and custom, it bids fair to disappear as a method of treatment. Dr. Shoemaker, of Philadelphia, in an article which appeared in the July number of the *Journal of Cutaneous and Venereal Diseases*, gives his opinion of this method, and his reasons for discarding it bear the impress of logic and common sense. In the first place as he states, the parasite is not eliminated by epilation, whereas thorough treatment will completely eradicate it, and when it has disappeared the hairs and their follicles will again assume a healthy and normal state. In the next place, he very justly claims that it is well-nigh impossible to epilate diseased hairs, from the fact that they are brittle, break off easily, and, even if successfully taken out, only aggravate the diseased condition of the follicles. Cutting off the hair or shaving it is also a very poor method; for when the applications are rubbed in the scalp the stubby hairs are disturbed to such an extent as to increase the irritation about the follicles. The proper method of treatment is to use parasitocides and avoid all conditions which tend to nourish the parasite. One of the best methods of avoiding the latter is to discard water altogether. Applying water to the skin only renders it in a better condition for the nourishment of a parasite which has lodged there.—*Med. Review.*

PHOSPHORUS IN TUBERCULAR DISEASE.—I can quite understand the remarkable success that has attended Dr. Greenway's treatment of tubercular meningitis by phosphorus. Phosphorus is a nutrient for exhausted nerve substance, and it certainly seems a powerful absorbent of recent exudations. Phosphorated oil has even been said to promote the absorption of a cataract if it be rubbed over the eyebrow. In meningitis we have an exudation of yellow lymph at the base of the brain, beneath the arachnoid, and in the web of the pia mater. Prior to absorption lymph undergoes a fatty transformation or solution, and this condition is speedily brought about by phosphorus, for the drug is well known to bring about fatty change in organs. Pathological knowledge therefore seems to point to it as a fitting medicine.

I have employed phosphorus as well as the phosphites of potash and soda, and under the influence of these preparations have seen pleuritic thickenings melt away. Old standing consolidations of the lung that had existed for one, two and three months, I have seen at once begin to move and disperse as soon as the hypophosphite of potash was given; and cases that have appeared to myself and others very much like acute tubercle in the lungs have sometimes recovered on the hypophosphites.

I commenced about twenty years ago with phosphorated oil as a medicine, but owing to its nause-

ous taste I took before long to the use of the hypophosphite salts, which contain phosphorus in a very low state of oxidation; and certainly, in those lung diseases which are of inflammatory exudative origin, and apt to run into phthisis, I know of no remedy to compare with the hypophosphites.

Before the discovery of the tubercle bacillus I had come to the conviction, from observation, that there were cases of lung disease where something seemed most decidedly to stop the way towards recovery by means of drugs given by the stomach. If inflammation be the sole agent that destroys the lung in phthisis, I should regard very few cases as incurable. It is the bacillus that seems to set the phosphorus treatment at defiance, and I notice at Victoria Park Hospital, that just when I find the hypophosphites most helpless, then it is that my clinical assistant finds "lots of bacilli."

A few weeks ago we turned out as cured a case of unmistakeable disease of the upper third of one lung, and in that case no bacilli were found.—J. C. Thorowgood, F.R.C.P., in *Brit. Med. Jour.*

REMEDY FOR RHUS POISONING.—As this is the season when many persons are making excursions into the country, it is to be expected that there will be many who will suffer from poison contracted by contact with the poison oak. Various remedies have been employed to relieve the suffering thus occasioned, but while one remedy is advantageous to some persons it utterly fails with others. Having learned of a great number of cases in which the fluid extract of *serpentaria* has been used with remarkable success, I thought it would be well to communicate the fact to your journal, as I have never seen it noticed in medical or pharmaceutical journals. It is best applied by placing cloths moistened with the extract upon the affected parts, without any friction. Two or three applications generally effect a cure.—*Am. Jour. of Pharmacy.*

SALICYLIC ACID IN THE TREATMENT OF LUPUS.—I have for some time employed salicylic acid in the form of ointment, as a remedy for eczema of the scalp and impetigo contagiosa in children, with the most satisfactory results, cases that had defied all other treatment yielding rapidly to its agency, and I have been induced to make a further trial of it in other skin affections.

By the kindness of Mr. Rigby, surgeon to the Doncaster Infirmary, I was permitted to employ it in a very bad case of lupus exedens.

The patient, a woman about twenty-five years old, had her face terribly disfigured, the ulceration having destroyed one ala nasi, the whole of the cheek and eyebrow having been involved. She had been in the hospital before, and had improved under treatment with Donovan's solution and a visit to Harrowgate. But on her return, though she was kept under treatment and observation,

fresh tubercles developed, and the parts that had cicatrized soon became again involved, and she was re-admitted to the institution. I first tried an ointment of fifteen grains of the acid to an ounce of cosmoline, which was of no use; I then increased the strength to a drachm, and then to one drachm and a half to the ounce.

The ulcers soon began to heal, no fresh tubercles appeared, the cicatrices became soft and lost their shiny, unhealthy appearance, and the skin of the face is now almost sound. She was previously taking a mixture of Donovan's solution and the liquor ferri dialysati. But as this had been without apparent benefit, I think it fair to give the credit to the external remedy. I have not heard of salicylic acid being employed before in the treatment of this disorder, and its action seems very satisfactory, especially as it does not seem to cause much irritation.—*Brit. Med. Four.*

TREATMENT OF FISTULA IN ANO.—Dr. Poingt claims (*Le Courrier Medical*) that any fistula amenable to treatment by the elastic ligature may be cured by simple drainage of the fistulous tract. The drainage tube is to be inserted by means of a stylet passed up the tract from the external opening. At the end of two or three weeks the drainage-tube falls out, after having destroyed the superficial wall of the fistula. A granulating surface of small extent is left, which rapidly heals by cicatrization. The procedure is wholly painless, and the patient may pursue his ordinary avocation during the entire course of treatment. The operation is never followed by any of those serious complications sometimes seen after the cutting operation.—*Southern Clinic.*

THE NUMBER SEVEN.—Hippocrates believed there was "luck in sevens," and he, like Shakespeare, divided the life of man into seven stages, holding that the number seven is the fountain of all the changes in life. For instance, the teeth appear in the seventh month or sooner, and are shed and renewed in the seventh year, when infancy is fully changed into childhood. At twice seven years puberty begins. At three times seven the adolescent faculties are developed, manhood commences, and men become legally competent to complete civil acts. At four times seven man is in full possession of all his strength. At five times seven he is fitted for all the business of the world. At six times seven he becomes wise, if ever. At seven times seven he is in his apogee, and from that time decays. At eight times seven he is in his first climacteric. At nine times seven he is in his last or grand climacteric, and at ten times seven he has approached the normal period of life.

There are some remarkable septenary coincidences in the discharge of physiological functions, and in disease processes. The human female men-

struates in four times seven days, and in forty times seven days she gives birth to her child. The period of gestation in animals is, in many if not in all instances, a multiple of seven. In the dog it is nine times seven days; in the cat, eight times seven; in the fox, six times seven. The common hen sits on her eggs three times seven days; the duck and goose, four times seven; the crow, three times seven; the swan, six times seven; the peacock, four times seven; the canary and pigeon, twice seven. Bees hatch out in three times seven days. Fever and ague has a tendency to terminate spontaneously after the 7th, 14th and 21st paroxysms. Relapsing fever is a disease of seven days' duration. Typhoid fever lasts three times seven days. The incubation of measles is twice seven days, and the disease itself lasts seven days—three days of catarrh and four of eruption—before it declines. Scarlet fever and erysipelas occupy seven days. Small-pox requires twice seven days—from the time of the appearance of the primary fever and the full development of the eruption, seven days, and in seven days more the whole crop of pustules has been converted into desiccated scabs. Truly, there is something wonderful about the number seven.—*Med. Age.*

DOCTOR'S MISTAKES.—At the recent meeting of the Kentucky State Medical Society, a number of the members grew quite confidential, and related, when in that mood, some experiences which it is not customary to see recorded in the public prints. For instance, Dr. Stone told of a German woman, the mother of three children, whose case was pronounced to be one of simple ascites. Several physicians, among whom was a distinguished professor of surgery, saw the case, and the latter used the sound and speculum to verify his diagnosis, preparatory to the operation which he contemplated performing for the removal of the left ovary. The manipulation excited some contractions of the uterus, during which a large clot of blood was expelled. After these symptoms passed away, an able obstetrician and professor, and an author of national reputation, was called in, with a view to making the diagnosis doubly sure. He, too, examined with sound and speculum, and diagnosed the existence of two tumors, one the enlarged and sub-involved uterus, the other of doubtful character, probably cystic, developed within the broad ligament. The sound, when withdrawn, as in the previous examinations, was covered with blood, and pains came on soon afterwards. In fifteen minutes, a clot of blood and three pints of water passed from her vagina, and a few hours later the woman gave birth to a six and a half months' child, which lived till morning and died.

Dr. Yandell, of Louisville, related several experiences which, recorded in detail, would make quite as interesting a report as that by Dr. Stone. He

knew of two or three such cases as that reported by the doctor. Prof. Miller and Prof. Baylis diagnosed an abdominal tumor to be ovarian, and not until the woman gave birth to a child did they discover their mistake. Some years afterwards a woman came up from Mobile. She had a tumor. She was a widow. Parvin saw it, Miller saw it, Thomas saw it. All declared it to be a fibroid. In the fall she gave birth to a child. Dr. Y. saw a case four years ago of an enormous tumor pronounced by Parvin, Gross and other eminent men, with himself, to be a fibroid. The woman was put on muriate of ammonia and ergotene. One night, after about three years of such treatment, she was seized with all the symptoms of peritonitis, collapse and shock. She was tapped, and an enormous quantity of fluid was drawn off. The cyst refilled. Dr. Yandell operated on her afterwards for its enucleation, and while the operation was as easy as it was possible to do, the woman died.

Such cases show simply that the wisest and most experienced of us make mistakes.—*Med. Age.*

RECTAL FEEDING AND MEDICATION.—Dr. Wm. Julius Mickle gives some very useful hints in a paper on this subject published in *The Journal of Mental Science*. In using nutrient enemata he advises that : Alcohol should not be added to albuminous food. If necessary, the bowels should previously be cleared out by a simple or aperient clyster, and a daily copious cleansing clyster is required in some instances. The bowels may have to be rested, but we must persevere if the first attempt fails. Where it is apt to return, the patient's best position to receive the enema is on the back or left side. The nozzle or tube should be comfortably warm, so should the food injected. The amount injected may sometimes with advantage be small at first, gradually increasing from 2 to 10 ozs. If the foods are ejected, we may try the plan (Dr. Hine's) of depositing them higher up in the viscus by means of elastic tubing and a funnel. But plugging the anus is often necessary, and has been done in many cases. Conflicting as are the results of experiments on the subject, he concludes that the rectum and colon digest but little, and that, even when inverse peristole is set up, the action of the bowel upon enemata is chiefly absorptive. If so, the food should either be introduced mixed with digestive substances, or else before administration in some way or in some measure be digested, and ready for absorption into the venules and lymphatics of the intestinal walls.

The following methods are all considered good :
Leube. Three parts of meat to 1 part of pancreas, both finely minced and mixed with a sufficient quantity of warm water for clysis. Carefully remove all fat and connective tissue. The hog's pancreas is the favorite.

Rennie. To a basin of good beef-tea, add $\frac{1}{2}$ lb.

shredded lean raw beef ; 3j fresh peps. porci ; 3ij dil. hydrochloric acid ; warm for four hours, stir frequently. Beaten egg or alcohol (?) may be added.

Catillon. A saturated solution at 19° C. of pepsone of meat, 40 grammes ; water, 125 grammes ; laudanum, 3 to 4 drops ; bicarb. of soda, 3 centigrammes.

Dobell. Cooked, finely grated beef or mutton, 1 lb. ; pancreatic emulsion, 1 oz. ; pancreatic powder, 20 grs. ; pepsine (pig's), 20 grs. Mix quickly, add half an ounce of brandy, and warm water sufficient to bring it to the consistence of treacle.

Henninger. Very lean meat, finely minced, is placed in a glass receiver ; water and hydrochloric acid are poured on, and pepsine, at the maximum of its activity, is added. The whole is left in a water-bath or stove to digest for 26 hours at 113° F. ; it is then decanted into a porcelain capsule, brought to the boiling point, and whilst the liquid boils a sol. of sod. carb. is added to it, until it shows a very slight alkaline reaction. Then the boiling liquid is passed through a fine linen cloth. The liquid is reduced in bulk in a water-bath. White sugar is added before administration.

Mickle. A pint of milk, with one-fifth or one-fourth of a pint of water, is carefully heated to 140° F. Two drachms of liquor pancreaticus and 20 grains of bicarbonate of sodium in one or two ounces of water, are added. The whole, in a covered vessel, is kept near the fire at 140° F. for an hour or an hour and a half, then thoroughly boiled for two or three minutes. Thus prepared the food keeps for half a day or a day.

Dr. Mickle uses enemata of chloral hydrate in many cases of epilepsy and of epileptiform seizures. He gives thirty grains dissolved in two ounces of water, and has found it very useful.

THE NEW HYPNOTIC.—If paraldehyde should prove as reliable as the reports thus far published seem to promise, we have in it a really valuable hypnotic. The latest observer is Dr. E. Kurz, who in the *Gentrlb. f. d. cl. Med.* (18, 1884), gives the results of his experiments with the remedy on twenty-four cases. With few exceptions the effect was favorable. Usually he administered the drug in the dose of three, sometimes four grams (gr. 1. to gr. lxx.) and in watery solution. But in this manner taken the remedy has a very disagreeable taste, and Dr. Sutter, of Illenau, recommends rum as a medium. Paraldehyde is incorporated in sugar, so that in the form of troches, one of these contains sixteen grains. Three or four of them, according to Sutter, are then dissolved in rum and a few drops of essence of lemon added. Thus prepared, the disagreeable taste is utterly concealed, and the patients do not object to take it. Its administration in *refracta dosi* is not so reliable as the effect of a single large dose. In most of K's twenty-four cases

insomnia had been complained of for a long time, and had not yielded notwithstanding the use of narcotics.

We will mention some of the diseases in which it was employed by K. for sleeplessness:

1. Phthisis, after repeated administration of paraldehyde, prompt effect.

2. Insomnia, with great restlessness after several days of railroad travel: perfectly quiet sleep restored after first dose.

3. Large ulcerated carcinoma of the mamma: after the pains had been subdued by hypodermic injections of morphia, sleep was induced by paraldehyde. Morphia and cannabis indica had not been effectual, and chloral had caused only excitement.

4. Insomnia, after violent psychological excitement: chloral had here also caused sleep, but been followed by severe headache; effect of paraldehyde instantaneous.

5. Mitral insufficiency with severe dyspnoea: neither morphia, cannabis, nor chloral caused sleep; paraldehyde did so, but partially.

6. Insomnia after typhus: morphia produced excitement; cannabis was useless; paraldehyde acted promptly.

7. Acute melancholy: prompt effect.

8. Insomnia in childhood: paraldehyde caused a quiet slumber.

9. Intra-orbital neuralgia: paraldehyde induced sleep but the effect of cannabis was still better.

The same was noticed in a tenth case, where chronic otitis had produced the sleeplessness.

Of the twenty-four cases but four evinced no or but partial hypnotic effects from the remedy. The opposite effect, excitation, as often observed from morphia and cannabis, was not seen in any case in which paraldehyde had been employed. Sleep generally set in within thirty minutes, and lasted from five to seven hours. Even in the few cases in which no hypnotic effect ensued, the patients admitted having felt much quieter after the paraldehyde; pulse became slower and arterial tension lessened, if previously increased; disagreeable effects were never noticed.—*Med. and Surg. Reporter*.

HAZELINE IN MENORRHAGIA.—According to Mr. Henry M. Chute, menorrhagia is a very frequent ailment of women in Cape Colony. He has found a valuable remedy for it, he says, in the extract of American witch hazel (*Hamamelis virginica*) or hazeline, in doses of half a teaspoonful, in sugared water, twice or three times a day. Mr. Chute states that it acts so quickly that it is not necessary to anticipate the flow, but when menstruation, after it has lasted the ordinary time, is not closing naturally, hazeline given as above will effectually restrain it, and after hæmorrhage has ceased there is no advantage in continuing it. While thus taken, some patients have mentioned that they have a

pleasant sense of exhilaration, of being strung up, and have lost that wearying sense of languor felt at these times. Another good result hazeline produces is that, when there is dysmenorrhœa, it in a very quick and marked way relieves the pain. Mr. Chute mentions the case of a young lady who suffered severely—so much as to necessitate her keeping in bed, and who was once so bad as to require a hypodermic injection of morphia. Since she has taken hazeline, menstruation has been painless and not excessive as formerly.—(*South African Medical Journal*, Feb. 15, 1884.)

PILOCARPINE FOR DEAFNESS.—For all recent cases of deafness due to labyrinthine disturbances, whatever the primary cause may have been, Politzer tries the subcutaneous injection of a two per cent. solution of muriate of pilocarpine. He injects four drops at first, and gradually increases the dose to ten drops daily. He gets fairly good results in about one-half of the cases. I have seen three cases of persons totally deaf, who, after being treated in this way, could hear and understand loud speech spoken at the distance of a few inches from the ear; and Politzer has had one case of perfect recovery of the hearing after it had been absent for three years, and several other very satisfactory results following the use of this drug. He is about to publish the results of his experiments with the history of some of the cases. It is not known how pilocarpine acts in these cases, but the benefit derived from its use is certainly great in some of them.—*Boston Med. and Surg. Journal*.

NEW TREATMENT OF LUPUS.—Dr. Vidal (*Jour. de Méd. de Paris*) proposes a new method, viz., that of ether injection, to cause suppuration. He uses the common hypodermic syringe (Pravaz's), and injects from 5 to 20 drops for each injection, according to size of lupus. The injections are continued until pus formation is indicated by the fluctuation. The abscesses are then opened and the pus discharged, after which it is claimed healing takes place and the lupus disappears.

NEURALGIC DYSMENORRHŒA.—Professor Parvin (*Coll. and Clin. Record*) recommends the following for neuralgic dysmenorrhœa:

R—Tinct. opii,
Tinct. valerianæ,
Spirit ætheris comp.,
Tinct. castorei, aa f. 3 ij.—M.
Sig.—A teaspoonful every hour.

CHRONIC BRONCHITIS WITH ASTHMATIC PAROXYSMS.—Prof. Bartholow recommends Potassii iodidi, grs. xx., Liq. potassii arsenitis, gtt. ij.—Mix. Take every four hours during the paroxysm, and in the intervals between the attacks, ammonii iodidi, grs. v-x.—*Med. Bulletin*.

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, OCTOBER, 1884.

The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

OVER-EATING AND UNDER-EATING.

We cannot imagine a closer connection between any two things than that which exists between life and nutrition. The continuance of life is dependent on the continued supply of nutrition. Even the quality or kind of life, speaking of life in an unrestricted sense, is largely influenced and moulded by the quantity and quality of nutrition supplied. Consequently we notice variations in the form and life of the plant, or the individual, according as nutrition has been normal, insufficient, or in excess. Every living thing calls for its own peculiar and natural supply, and flourishes best when a normal standard is regularly maintained. Insufficiency and superfluity of food are both usually followed by marked departure from the normal life standard. No one need be told that insufficient alimentation, in both kingdoms, is followed by a train of consequences very much similar—that the plant, or the individual, soon shows loss of health and vigor, gradually diminishes in size, and if the process of decay is permitted to proceed, finally dies. Owing to the more complex nature of the organs of assimilation in animals, and other causes needless to mention, the results of excessive alimentation are not so uniform in their operations as those of insufficient alimentation, as applied to the two kingdoms. There may be, and doubtless there are exceptions, still the rule is, even in the vegetable kingdom, that excessive alimentation is an evil to be avoided. The over-nourished wheat-stalk grows

coarse and rank, but the grain is either wanting or is poor in quality. The rule more than holds its own when we ascend to the animal kingdom. Every one must be aware that even brutes suffer harm from over-feeding. But it is not till we arrive at man, that we witness all the baneful consequences of excessive alimentation.

An honored teacher of medicine, the late Dr. Rolph, used to say to his class: But few eat too little; most eat too much. The truth of that laconic remark is known to every observant person. We all know that the largest eaters are not necessarily the largest nor strongest of the race. The very opposite is nearer the mark, notwithstanding a few notable exceptions. No homely aphorism was ever truer than this one: "He eats so much that it makes him poor to carry it." It is a fact that a large majority of the lean and sickly amongst us are immoderate eaters, while a majority of the healthy and robust are moderate, or small eaters. The reason of this is easy to find. He who eats more than nature demands, imposes a heavy strain on the organs involved in the process of digestion and elimination. The stomach has a more or less definite digestive capacity, which if unduly overtaxed results in imperfect digestion, impure blood, disordered function, and gradual decay. Just as certain as we exceed the natural bounds set by nature, and overtax our stomachs to please our palates, so surely do we begin to sow the seeds of disease. True, the stomach is elastic, and marvellously accommodating, and bravely resists the assaults imprudently made on its inherent rights; but like the stone, under continued dropping, it gradually wears out.

While no reasonable person will take exception to these remarks, it is open to question, whether medical men generally are so impressed with the importance of the truth they embody as its importance merits. We hear a great deal said about "abundance of nourishing food," but very little about over-abundance. If the patient be reduced in flesh, it is too readily assumed that what he most needs is plenty of beef and other good things, while the truth may be that he has been by far too well supplied all along. Let any medical man keep a record of those chronically affected who apply to him for relief, and he will soon find that the vast majority of them have good appetites—too good in fact, and eat "abundance of nutritious food." He will find that the vast majority of this class of pa-

tients are suffering from troubles of the digestive organs, not secondarily but primarily. They are living witnesses of the literal truth of the saying, before quoted, "he eats so much that it makes him poor to carry it." For the physician to recommend a continuance of an over-generous diet under these circumstances, is to aggravate the evil. Even in the case of the under-fed it may be improper to do so, for in a weakened condition of the system it is easy to overtax the organs of digestion and so defeat all attempts at striking at the root of the malady. That physician who best excels in gauging the wants of the system and its power of assimilation, will be most successful in the cure of disease.

We do not contend that there are no under-fed or starved people in the world, or no ailment traceable to this cause. Unhappily there is too much of both. Still, outside the great centres of population, the number of the debilitated and diseased from lack of food is small, in this country. Happily for our people they have a goodly heritage, where food is both abundant and cheap, and easily obtainable by all who are able to work for it. This great and inestimable blessing is not unmingled with evil. A well laden table is sure to lead to over-indulgence, and hence we find in this country, and amongst our neighbors, more dyspeptics than can be found in all the world besides. Let over-indulgence be discontinued and the saving thus effected given to the poor, and two classes shall speedily and simultaneously disappear—the dyspeptic and the hungry.

THE CANADA MEDICAL ASSOCIATION.

The seventeenth annual meeting of the Canada Medical Association was held in Montreal on the 25th, 26th and 27th of August, and was largely attended. To say that this was by far the most successful meeting in the history of the Association is but to express the simple truth. A number of the members of the British Association for the Advancement of Science not only honored the meeting with their presence, but also took an active part in the proceedings, and gave increased interest and zest to the discussions. The papers were upon the whole very good, and were in most instances fully discussed. The event of the meeting was of course the address on "Abdominal Surgery," by Mr. Lawson Tait, of Birmingham, which will be found in another column. He was accorded a very

enthusiastic reception, and the address was received with marked attention. He is a man of fine presence, speaks with a slightly Scotch accent, has a good style of delivery, and speaks with the confidence of a man who knows his subject thoroughly. The discussion which followed was also very interesting and instructive. Among those from abroad who took an active part in the proceedings may be mentioned, Drs. Protheroe Smith and his son Heywood Smith and Dr. Harley, of London; Dr. Struthers, of Aberdeen; Dr. McMillan, of Hull; Drs. McGrath and Brodie, of Detroit; Dr. Brush, of Utica; Dr. Elsberg, of New York, and others.

The Association, as in former years, was divided into two sections—Medicine and Surgery. Dr. Thorburn, of Toronto, was appointed chairman of the former, and Dr. Roddick, of Montreal, chairman of the latter. The sections met in the afternoons and evenings, and the forenoons were devoted to the general work of the Association.

The President's address consisted of a brief review of the founding of the Association and the general progress of medical science and medical education in Canada. He took occasion to praise our one-portal system of licensing in Ontario and expressed the hope that the sister Province of Quebec might soon follow in our wake, and that ere long we might have one portal for the entire Dominion. An epitome of his address will be found among the proceedings.

The profession of Montreal, so noted for their hospitality to strangers, far exceeded any previous effort in this direction, and the occasion will long be remembered by those who participated. The banquet at the Windsor was a most magnificent spread, the large dining hall being filled with guests. About two hundred sat down to dinner, among whom were a goodly number of the members of the British Science Association, both medical and lay. Dr. Hingston presided and acquitted himself in his usual happy manner, and was ably supported by Drs. Grant, F. W. Campbell, T. Rodger and Roddick in the vice-chairs. The after-dinner speeches were very good and a pleasant evening was spent by all who had the good fortune to be present.

Dr. Osler was unanimously chosen President for the ensuing year, and Winnipeg selected as the next place of meeting, on the third Tuesday in August, 1885.

MEDICAL MEN'S FEES.

A test case was recently tried in Belleville; Ont., to determine whether or not a patient is liable for the fees of a medical man who is called by a friend or relative. In this case the brother of the patient summoned the consulting physician, who assisted in the amputation of a finger. The patient refused to pay the consulting physician on the ground that he had not engaged him, and told him to look to the attending physician for his fee. The Judge who tried the case ordered a non-suit, holding that the patient was responsible only to the physician he engaged. We are a little surprised at the ruling of the Judge in this case, as we had always entertained the idea that if the patient accepted the services of a physician, he was bound to pay him. It is a well-recognized principle among the medical profession that when a medical man is called in consultation the patient is responsible for the payment of the fee. In view of the Judge's ruling in this case the question might well be asked, Who is to be responsible for the fees where the patient is unconscious and incapable of engaging anyone? One not versed in the intricacies of the law would naturally suppose that a patient's brother could safely be considered an authorized agent to engage the services of a medical man, but such it seems is not the case. And if a patient is not responsible for the fees of a medical man who has been engaged by his brother, what are the chances of having a legal claim to remuneration for services rendered when the party who calls the physician is only a neighbor, a friend, or, in case of emergency, possibly a stranger?

MALPRACTICE SUIT.—A suit to recover \$2000 damages for alleged malpractice was recently tried in Walkerton, Ont. The plaintiff, Mr. Robertson, received a fracture in the lower third of the thigh in November last, and the defendant, Dr. H. A. Bonnar, of Chesley, Ont., was called to treat him, which he did in the usual way by means of a weight and pulley, together with the use of coaptation splints. The treatment was continued eight weeks and upon examination there was found to be $\frac{3}{4}$ of an inch shortening, besides a considerable degree of angular displacement at the seat of fracture. There was also some stiffness of the knee joint.

The plaintiff alleged that the defendant had not treated the fracture properly, and also that he allowed him to use his limb before union had taken place. The plaintiff's views were supported only by the evidence of Dr. Cooke of Chesley who was called in to treat the patient after Dr. Bonnar had discontinued his attendance. For the defence it was shown by Drs. Fulton and White of Toronto and several other medical gentlemen in the locality, that Dr. Bonnar had treated the plaintiff skillfully and carefully, and was not in any way to blame for the result. The shortening was not more than the average in fracture of the thigh, and the deformity did not interfere with the utility of the limb. At the close of the plaintiff's case the Judge said there was no evidence to go to the jury as to the allegation that the method adopted by the doctor was an improper one, as it had been proved to be a method sanctioned by the highest authority. He would have to leave the other portion of the case to the jury, as to whether the doctor had carefully attended his patient and to say whether the result had been what might naturally be expected if the plaintiff had been properly treated, even assuming the method adopted to be a proper authorized one. The jury failing to agree were discharged. We congratulate Dr. Bonnar on the result of the trial.

ONTARIO MEDICAL COUNCIL ELECTIONS.—The following gentlemen have been recently nominated as candidates for the Erie and Niagara Division in the Medical Council, viz.: Dr. Philip, of Brantford, and Dr. Thos. T. Harrison, of Selkirk. With one or two exceptions the old members will be candidates for re-election, and as they were for the most part faithful to their trust, we hope to see them returned. We give the following extract from the by-law for conducting the elections which take place on the 4th Tuesday in May, 1885:

"Any member presenting himself for election as the Representative to the Medical Council for a Territorial Division, must receive the nomination of at least ten (10) registered practitioners resident in such division, and such nomination paper must be in the hands of the Returning Officer for the division not later than 2 o'clock on the afternoon of the first Tuesday in May, 1885. The Registrar shall send to every registered member of the College, entitled to receive the same, a voting paper,

(in accordance with residence given on the register), by the second Tuesday in May, 1885. Any member of the College not having received a voting paper, when more than one candidate has been properly nominated for his division, will send by post to the Registrar his name and address."

GUN-SHOT WOUNDS OF THE INTESTINES.—Dr. Parkes, of Rush Medical College, Chicago, has been experimenting on gun-shot wounds of the intestine in dogs, and gives the result in a paper read before the Am. Med. Association. The experiments show in the most unmistakeable manner the utility and value of abdominal section, and stitching of the bowel. He recommends a modification of the *Lembert* suture, as the most satisfactory, but states in conclusion that it makes no difference what kind of suture is used, so long as the principle of securing the application of two broad surfaces of peritoneum in contact with each other is carried out. He used both silk and catgut. The sutures were introduced about the third of an inch from the divided edges, made to include the peritoneal and muscular coats *only*, and brought out just free of the edge on one side, and similarly inserted on the other. The lacerated part was first excised and bleeding arrested.

LIGATURE OF THE COMMON CAROTID.—Dr. W. Honeywell, of New Glasgow, P.E.I., with the assistance of Drs. Toombs and Gallant, of Cardigan, successfully ligated the common carotid, below the cricoid cartilage, a short time ago. The patient, a sailor, fell down stairs in a vessel on a piece of earthenware, which penetrated his neck below the under jaw, making a ragged wound about two inches deep and wounding the external carotid. The usual incision was made along the anterior border of the sterno-mastoid, and the vessel tied with a prepared violin string (this was kept in oil of juniper for six weeks, then put in alcohol). The wound was washed out with a solution of corrosive sublimate (1 to 2000) then covered with iodoform gauze. It healed by first intention, and the patient recovered without a bad symptom, except a little vertigo.

PONTIAC COUNTY ASSOCIATION, QUE.—The members of the medical profession of this county, met at Portage du Fort on the 12th ult, for the purpose of organizing, revising the tariff and dis-

cussing matters appertaining to the fraternity. There was a good attendance present. Dr. Purvis was elected *President*, Dr. Lyon *Vice-President*, and Dr. Knox, *Sec.-Treas.*

A tariff of fees was considered and adopted. The annual fee to defray the expenses of the association was fixed at \$1. The association will meet three times in the year, on the second Tuesday of May, January and September. As there are a few medical men practising in the county without licenses it was unanimously agreed that proceedings be taken against them forthwith. The next meeting of the association will be held at Shawville.

COLORADO BEETLES IN THE STOMACH.—Dr. Harrison, of Keene, Ont., sends us the following: On July 9th, a child two years old was brought to his surgery very ill. The symptoms were indicative of intestinal and alimentary irritation, with tendency to stupor. He was doubtful about the cause, but thought it might be due to worms or something the child had eaten. He gave some powders of *santonine*, *aloine*, etc. Two days after the parents were amazed and alarmed at seeing the child pass a large quantity of Colorado beetles in the pupa state. The child continued to improve steadily as soon as rid of the offenders. Strange to say they did not appear to be the least inconvenienced by their sojourn in the child's stomach.

APPOINTMENTS.—The following gentlemen have been appointed examiners under the Civil Service Acts, 1882 and 1883:—Drs. M. Sullivan, Kingston; C. J. Samson, Quebec; P. Conroy, Charlottetown, P. E. I.; J. B. Matthews, Victoria, B.C. W. Canniff, Toronto; and Dr. Codd, Winnipeg.

Dr. C. W. Belton, has been appointed medical superintendent of the London General Hospital, *vice* Dr. Wilkinson resigned.

Dr. Bruce, of Woodstock, N. B., has been appointed on the staff of the St. John Public Hospital, *vice* Dr. Coleman, who is about leaving the city.

ERGOT IN CHOREA.—The value of ergot in many affections of the cerebro-spinal system is well known. On the assumption that the smaller vessels of the brain, as Dr. Dickinson maintains, are in a state of *dilatation*, Dr. Forrest (*London Lancet*) has been experimenting with this remedy in

chorea. He began by giving the fluid extract in five minim doses, and the results have been on the whole satisfactory.

TREATMENT OF GONORRHŒA.—The following suggested by a retired army surgeon is going the rounds of the press as a cure for gonorrhœa—

R Zinci sulph.

Ext. Belladonnæ aa grs. xx.

Mucilag acaciæ ʒi

Aquæ ad. ʒviii.—M.

Sig.—A teaspoonful to be injected frequently. An ointment of opium, and belladonna also to be smeared along the perineum and crus penis at night.

HALDIMAND COUNTY MEDICAL SOCIETY.—At a meeting of the above-named society held in Caledonia on the 19th ult., the following officers were re-elected, viz.: Dr. Dee, *President*; Dr. Davis, *Treasurer*; and Dr. Forbes, *Secretary*. On motion of Dr. Harris, seconded by Dr. Baxter, Dr. Harrison, of Selkirk, was nominated for election to the Ontario Medical Council (1885) for the Erie and Niagara Division.

ARREST OF TUBAL PREGNANCY.—Dr. Mundé, of New York, reports in the *Medical Record* a successful case of arrest of tubal pregnancy by galvanism. One electrode was placed in the rectum and the other over the mass, and the strength of the current gradually increased to 24 cells. The patient though much prostrated at the time made a good recovery.

PROFESSIONAL EXAMINATION.—The following gentlemen have passed the supplemental examination for M.D. C.M. in McGill College. D. A. Cameron, Strathroy, Ont.; J. T. Mackenzie, Belleville, Ont.; J. A. McArthur, London, Ont.; and J. C. Sharpe, Sussex, N.B.

Dr. Lawson Tait, contrary to his original intention, has been doing some operative surgery on this side the water. In Hamilton, he opened the abdomen for supposed gall stones, but found carcinoma instead. In Albany and New York he performed three operations for removal of the ovaries and one hysterectomy.

PERSONAL.—Dr. Osler of Montreal was entertained by the Toronto Medical Society on the 25th

ult. prior to his departure for Philadelphia to enter upon his duties as Prof. of Clinical Medicine in the University of Pennsylvania.

ADMINISTRATION OF IRON.—To prevent the disturbance of the stomach, occasioned by tincture of iron, it should be combined with muriate of ammonia in the proportion of one part to two of the tincture. This also renders it more palatable.

PRURITUS.—The latest remedy for this troublesome affection, when seated in the anus or vulva is balsam of Peru. The *British Medical Journal* alludes to it as a new triumph in medicine.

The *Lancet*, September 20th, contains a notice of the death of Dr. Radcliffe, whose name has been so long associated with public health matters in England.

The next meeting of the International Medical Congress, as was anticipated in our last issue, will be held in Washington in 1887.

BRITISH DIPLOMAS.—Drs. T. McCullough and J. E. Brown (Trinity) have successfully passed the required examination for the L.R.C.P. Edin.

THE death of Prof. Cohnheim, of Leipsic, is announced in our foreign exchanges.

Books and Pamphlets.

A MANUAL OF DISEASE OF THE THROAT AND NOSE, including the Pharynx, Larynx, Trachea, Œsophagus, Nose and Naso-pharynx, by Morell McKenzie, M.D., Lond. New York: Wm. Wood & Co. Toronto: Hart & Co.

This is the second volume of the above-named work, embracing the "Diseases of the Œsophagus, Nose and Naso-pharynx," and constituting the August number of Wood's Library of Standard Authors. It is nearly twelve years, the author states, since the work was commenced, and during that time there is scarcely a page that has not been written and re-written many times. He has been at great pains to make the work a faithful exponent of the science and practice in this important department of medicine. The work bears evidence of the care and attention which has been bestowed upon its

preparation. The reputation of the author as a specialist in this field is too well known to require any notice at our hands.

A PRACTICAL TREATISE ON DISEASES IN CHILDREN, by Eustace Smith, M.D., F.R.C.P. Lond., Physician to the East London Children's Hospital. New York: Wm. Wood & Co. Toronto: Williamson & Co.

The opportunities of the author as well as his reputation as a practitioner, entitle his work to the favorable consideration of the profession on both sides of the Atlantic. The author discusses the whole subject of disease in early life, and deals with it purely from a clinical standpoint. Each subject has been treated very fully, and great care has been bestowed on the sections relating to diagnosis and treatment. Due prominence has also been given to the important subjects of diet and hygiene. Many interesting cases from the author's case-books, by way of illustration, have been introduced into the text. It is the most complete work of the kind in the English language, embracing in 12 parts the following: Acute infectious, non-infectious, diathetic, glandular, nervous, respiratory, circulatory, mouth and throat, digestive, hepatic, genito-urinary, and skin diseases. We commend the work to the Canadian profession.

THE POPULAR SCIENCE MONTHLY for September, 1884. New York: D. Appleton & Co. Fifty cents a number, \$5 a year.

The frontispiece of the September "Popular Science Monthly" is a fine portrait of Professor J. P. Lesley, chief geologist for Pennsylvania, and President of the American Association for the Advancement of Science. Prof. J. P. Cooke's article (Harvard University) on "Scientific Culture: its Spirit, its Aim, and its Methods," is an able exposition of this subject. In "National Health and Work," Sir James Paget strikingly presents an additional reason for sanitary activity in the loss which results to the nation from the sickness and early death of its workers. Among other articles may be mentioned: "Sorghum as a Source of Sugar," "Hygiene for Smokers," "Sun Kinks," "The Problem of Population," "Protection against Lightning," etc. The editor writes on the meetings of the British and American Associations, and discusses a recent article by Bonamy Price, under the heading, "The College Feitch once more."

A MANUAL OF OBSTETRICS, by Ed. L. Partridge, M.D., Prof. of Obstetrics New York Post-graduate Medical School, etc., with sixty illustrations. New York: Wm. Wood & Co. Toronto: Williamson & Co.

This is a very convenient pocket manual, and as such will be found useful by young men commencing practice, for reference in perplexing cases at the bed-side. The author has given a very concise and correct outline of this important subject, and medical students will find it valuable in making readily available their store of knowledge in a professional examination.

MANUAL OF AUSCULTATION, PERCUSSION AND URINALYSIS, ILLUSTRATED. By C. Henri Leonard, M.A., M.D. Detroit: Illustrated Medical Journal Co.

This unpretentious little work contains a complete epitome of the physical signs of the heart, lungs, liver, kidney and spleen in health and disease. The matter is so condensed that a great deal of information is compressed into a very small compass. The illustrations are fairly good and the text clear and explicit. Dr. Leonard is quite an adept at this kind of work, having already published several of like nature, such as "Vest-Pocket Anatomist," "Reference and Dose Book," "Bandaging," "Hair and its Diseases," etc.

THE CARE AND FEEDING OF INFANTS, by Doliber, Goodale & Co., Boston, Mass.

This pamphlet, which deals with the essentials of feeding infants, invalids, etc., will be sent free to any address on application.

VISIONS OF FANCY. A poetical work, by N. M. Baskett, M.D., of Moberly, Mo. St. Louis, Mo: Commercial Printing Co.

Births, Marriages and Deaths.

At Moorefield, Ont., on the 14th ult., Dr. Henry Mandesley, aged 54 years.

At Arichat, N. S., on the 13th ult., Henry C. Fixott, M.D., M.R.C.S., Eng., aged 64 years.

On the 25th ult., Dr. Edward Morton of Queensville, Ont.

On the 11th ult., Dr. G. A. Kent, of Wallace, N.S.

THE CANADA LANCET.

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Original Communications.

THE EFFECTS OF TOBACCO.*

BY W. F. COLEMAN, M.D., M.R.C.S., ENG., ST. JOHN, N.B.

Mr. President and Gentlemen,—At our last meeting the President referred to a case of faint cardiac murmur in a very healthy man who smoked a good deal, and questioned as to the possible connection between the tobacco and the murmur. This suggested to me "The Effects of Tobacco" as a subject for this evening's consideration. In regard to one field of observation, I have a very decided view, and am anxious to get the benefit of your experience in a more general field. The universality of puffing and chewing the fragrant weed, and the potency of tobacco as a poison, make the question of the effect of its habitual or remedial use an important one. Tobacco belongs to the family solanaceæ, which embraces such members as hyosciamus, belladonna, stramonium, and curiously enough, the potato. Its important active principles are a colorless liquid alkaloid, called nicotine, a poison "which almost equals hydrocyanic acid in activity" and a camphoraceous volatile oil, nicotianin. By burning tobacco, an empyreumatic oil is produced from the decomposition of some of its constituents, which as found in the pipe of the smoker, is an active poison, and appears to be (Christison says) nicotine attached to a true volatile oil. The proportion of nicotine varies in different sorts of tobacco, and the quantity usually present is by various chemists estimated from 2% to one part in ten thousand. Two or three drops of nicotine or 3ss. of tobacco may cause death. The death of two brothers is reported from the continuous smoking of 17-18 pipes. Pereira gives a case in which twelve drops of an infusion of tobacco given as an enema caused death.

Von Boeck on vegetable poisons, says, "It is from smoking tobacco that nicotine poisoning chiefly arises, the smoke itself containing the nicotine. A great deal of it accumulates on the lower part of the pipes, and the remains of cigars are much more impregnated with it than the parts fresh smoked. Large poisonous doses of tobacco are said to produce syncope, small pulse and labored respiration. In most cases convulsions supervene. The pupils are at first dilated, then contracted. There is prolonged collapse and finally death."

Erb, of Heidelberg, says: Various authors adduce excessive tobacco smoking among the causes of tabes dorsalis. I would here say, in anticipation, if we can prove, as we think possible, that tobacco smoking often produces inflammation and atrophy of the optic nerve, is it not more than probable that it can and does produce myelitis, followed by atrophy of the cord, the admitted pathology of tabes dorsalis. Beau describes eight cases of angina pectoris, in which the attacks ceased when smoking was stopped, and returned when the patients began to smoke. Headland places tobacco under the class neurotics, order inebriants. The observations of Claude Bernard that nicotine at first produces contraction of the arteries, and later on the vessels become distended, agree with the results of the physiological researches of Uspensky, who concludes that nicotine first stimulates then paralyzes the vaso-motor centres.

From personal experience and the literature at my command, I know of no more constant detrimental effect of the abuse of tobacco than impairment of sight, ranging from slight defect to total blindness. The abuse of tobacco is so frequently associated with drinking to excess, that it is questioned by some whether tobacco alone ever produces impaired sight, or whether the tobacco or alcohol is the chief factor. My own opinion is, that tobacco alone is quite able to produce imperfect sight. Dr. Webster, of New York, in an able paper reporting twenty cases of amblyopia from the abuse of alcohol and tobacco, remarks, "That the abuse of alcohol alone, or of alcohol and tobacco combined, may produce impairment of vision, no physician acquainted with the subject will, I think, venture to deny. Some, however, doubt that tobacco alone ever causes impairment

*Read before the New Brunswick Medical Society.

of vision, and indeed it is difficult to demonstrate that it ever does." Now, in looking over Dr. Webster's cases, I find not one in which the patient who used alcohol did not *smoke* to excess. On the other hand two who smoked to excess used so little alcohol that I think even Dr. Webster would not claim it had any share in the effect upon sight, proving, so far as Dr. Webster's cases are concerned, that tobacco alone may impair sight, and that in no case was alcohol the only or even the chief factor in the causation of the amblyopia.

E. g. Case 7, C. McK—, æt. 49. Has smoked 10-15 strong cigars daily for ten years; *occasionally* drinks a glass or two of gin. Vision = $\frac{1}{16}$ each eye. Incipient atrophy of optic nerves.

Case 12, æt. 60. Sight failing over a year. Has smoked a strong pipe most of his waking hours for more than forty years. Has *rarely* tasted liquor. Vision equals $\frac{1}{40}$ each eye. Brick dust atrophy of both optic nerves. Ordered to stop tobacco, and return in a week. *Then* vision in right eye *doubled*, in left eye all but doubled.

McKenzie, one of the worthy fathers of ophthalmology, originally pointed out the effects of tobacco. In 1840 he wrote, "I have already had occasion repeatedly to hint my suspicion that one of the narcotico-acrids, which custom has foolishly introduced into common use, namely tobacco, is a frequent cause of amaurosis." In that pre-ophthalmoscopic day, amaurosis meant obscurity of vision, depending upon a supposed morbid condition of the retina or optic nerve (McKenzie). In the present day, the terms amaurosis and amblyopia give rise to great confusion, from their various application. It would perhaps be best to restrict the term amblyopia to all cases of impaired sight, and amaurosis to cases of absolute blindness, without ophthalmoscopic symptoms. More recently, Wordsworth, Critchett, Hutchinson, &c., have given great attention to the effects of tobacco upon the eye, and believe it gives rise to impaired sight and blindness, with or without ophthalmoscopic signs. Hutchinson, who is probably the best authority on tobacco amaurosis, wrote in 1867 as follows: "The first stage, one which is very transitory, and perhaps often altogether omitted, is one of congestion, during which the optic disc looks too red. Then follows pallor of the outer parts of the nerve disc. During these stages the patient complains of dimness of vision merely. In a later

stage the whole disc has become pale, even to blue milk whiteness, and later still there is advanced atrophy. The stages generally occupy from four months to a year. In many cases the patient becomes at length absolutely blind, but in others the disease having advanced to a certain point, is arrested. There is from first to last no evidence of any disease of any structure in the eyeball, excepting the optic nerve. Almost always both eyes are affected, and progress *pari passu*. Sleepiness, a little giddiness, and a little headache, are usually the only constitutional symptoms which attend it." Three-fourths of his cases recovered. In a personal interview with Mr. Hutchinson at Moorfield, in 1875, he remarked he had come to think the effect of alcohol antagonistic to tobacco, as a cause of amblyopia, unless the alcohol is taken in such excess as to produce degenerative or undermining effects on the constitution. He had seen amblyopia more frequently and more advanced in smokers who abstained from alcohol, than in those who took it. Dr. Berry also holds a similar opinion. He cites two cases of tobacco amblyopia; one a man of seventy, who had been a teetotaller for forty years, and the other a boy of 19, who did not drink. Berry, in common with many others, has remarked the symptoms often gradually disappear on the cessation of smoking, without any other treatment, and frequently without the supply of alcohol being diminished.

Since Hutchinson's description of tobacco amblyopia in '67, he, in common with many others, has examined more systematically the field of vision and color vision, and has found that the diminution in sight is confined to central or direct vision, while usually, eccentric vision remained relatively good, and they have found that color-blindness exists over a portion or the entire extent of the visual field. The color-blindness is for red or green, the red appearing blue, and the green appearing white, gray or yellow. The color-blindness in slight cases of amblyopia requires very careful examination to determine, as it is confined to the central part of the field, particularly within an area stretching from the optic nerve to the macula.

In 37 cases of atrophy of the optic nerve, Hutchinson attributed 30 to the effects of tobacco, and in 36 cases of optic nerve atrophy, Lebr found color-blindness an almost constant symptom, the

perception of color remaining intact in only three. Berry says he has looked out for the symptoms of tobacco amblyopia in women for the last five or six years, and has only met with them in three cases. These three women smoked to excess, but did not drink. Forster cites 20 cases, in a paper on the injurious action of tobacco on vision, each one of the patients being a strong smoker, and only able to see very large type. In 11 of these cases marked improvement was observed when the use of tobacco was given up. I will not detain you by quoting the language in the text-books on diseases of the eye at my command, by authors who express their full belief in tobacco amblyopia and amaurosis, simply stating they are English, Scotch, American, German and French, and among the best authorities. The authors are, McKenzie, Wolfe, Gowers, Wells, Nettleship, Noyes, Williamson, Stellwag, Schweigger, Grunfeld, Mittendorf, Mayer, and De Wecker. The only two authors I have who dissent from the general view are Carter and Lawson, English. Carter quotes a letter from Dr. Dickson, of Constantinople, to the effect that the consumption of tobacco in that city averages 3 lbs. weight per head per month, but that amaurosis is a rare affection there. He quotes also Dr. Hubsch, oculist in Constantinople, who writes, "I have never attributed amaurosis to the abuse of tobacco." Carter adds, "I have obtained the same kind of negative evidence from Egypt and India, and in the face of it I do not attach much importance to the fact that several patients who have suffered from nerve atrophy, have been great smokers. If a patient who consults me on account of nerve atrophy is a smoker, I always advise him to lay aside tobacco. This would be dictated by the duty of leaving nothing undone, and would not represent any personal belief in the necessity of the prohibition." I cannot comprehend why Mr. Carter thinks it his duty to give advice in which he does not believe, unless he thinks the belief of others a stronger reason for his duty than his personal belief, in which case he must hold his own opinion very feebly. Mr. Lawson, one of the surgeons of Moorfield Eye Hospital, thus writes: "I do not remember ever having seen a case in which the loss of sight could be fairly attributed to tobacco only. There was also in addition to the immoderate smoking some other excess, such as intemperance, or undue mental strain with loss of rest."

In looking over my notes of 1824 eye patients who have consulted me since 1877, I find 46 who had partial to total loss of sight accompanied by conditions of the eye similar to those noticed in tobacco amblyopia, viz., either no ophthalmoscopic or otherwise detectable change of the eye, or else hyperæmia, pallor, or atrophy of the optic papilla. These 46 cases may be thus classified: male 33, females 13 (46). Cases referred to smoking alone, 13; tobacco and alcohol, 9; alcohol alone, 0; other causes, 24. Tobacco and alcohol, males 9, females, 0; tobacco, males 13, females 0; other causes, males 10, females 14. Cases in which there was hyperæmia, pallor, or atrophy of the disc: tobacco, 12 male; alcohol and tobacco, 9 male; other causes, 7 male, 11 female. In regard to these figures I would remark that although no case of pure alcoholic amblyopia appears, it is because every one of the drinkers who consulted me was an excessive smoker, a rule, perhaps, with few exceptions, yet I believe amblyopia potatorum is an entity, as is very generally held in Paris. I must admit not having questioned females as to smoking and drinking, as they are so free from such male virtues. Again, in all the cases but one of tobacco or tobacco and alcohol, I noticed changes in the optic disc, as the patients did not consult me in an early stage, when ophthalmoscopic changes are not noticeable. I will briefly refer to four patients who did not take alcohol and had tobacco amblyopia:

J. T., æt. 44, consulted me in Feb. 83, complaining that his sight had been defective for eight months, and he was unable to see more than half a word at a time with either eye, seeing the half on nasal side. Vision is one-half in left and one-third in right eye; outer half of each optic papilla pale. Patient has smoked six pipefuls daily for 15 years past. Advised to take strychnia and stop tobacco. Patient returned in two months, said he had followed advice and sight was all right.

H. O., æt. 21, Dec. 28, '83, said both eyes had gradually failed during the past 15 months, and now he can barely distinguish light. There is advanced atrophy of both optic discs. No symptoms of brain or spinal disease, no history of syphilis, health good. Has for four years past smoked 6-7 pipefuls daily, and chewed one-fifth lb. of tobacco weekly. *Treatment*—Strychnia, hypodermically, m iv. ter die. (grs. iv., ad 3 i.

solution) and increase mj. daily; stop tobacco. Strychnia spasm was not felt till the dose reached m xxv, equal gr. one-fifth, and then only occasionally felt. Vision remained the same after one month's treatment. Feb. 4, '84.—R Strychnia, gr. $\frac{1}{2}$ ter die, by stomach, and gradually increase the dose. Feb. 8th—Apply galvanic electricity to nape of neck and closed lids, three minutes daily to each eye. Feb. 27th—Taking strychnia gr. $\frac{1}{2}$ ter die, by stomach, and feels spasm only occasionally. Vision, each eye increased to $\frac{1}{10}$. April 7th, '84.—Discharged with vision $\frac{1}{10}$, and able to see his way about well. Patient only diminished the amount of his smoking.

Nov. 25, '80—J. McK, æt. 31. Sight failing three months. Vision, right or left eye, = $\frac{1}{17}$. Has smoked since 11 years of age, and for three years past 10 pipes a day. Takes a glass or two of whiskey only once in months. Both papillæ hyperæmic. *Treatment*—Stop tobacco, cup temples, take iodide of potassium. Jan. 5, '81—Patient returned; stopped tobacco and gained 12 pounds in weight. Vision has increased from $\frac{1}{17}$ to $\frac{1}{8}$. Outer half of discs now pale. Jan. 20th—White atrophic lines on discs and along vessels, perivascular atrophy; vision the same. Prescribed strychnia.

Oct. 22, '79.—W. S., æt. 21, noticed nine months ago while in school he could not see to read with right eye, and six months ago noticed the same defect in the left, but two weeks later could see to read fairly well. A week later still the eye again failed. With right eye can count fingers at 6" on temporal side only. With left eye, vision is $\frac{1}{41} = 1 = 16$ (Jaeger). Fundus of eye normal, unless there is some engorgement of retinal veins. Patient is anæmic and nervous, but he considers his health pretty good. Has smoked 6-8 pipes a day, from the age of 15, until two years ago, and 3-4 pipes daily since. Diagnosis, tobacco amblyopia. Prescribed strychnia. Discharged after nine days' treatment, with vision of right eye increased 8 times, and doubled in left eye. Continue strychnia by stomach.

Finally, gentlemen, I am prepared to hear you maintain that impaired sight, the use of tobacco, and the wearing of leather boots, for instance, are coincidences, only that and nothing more. The only additional argument in favor of tobacco amblyopia I shall detain you with is, that the quality

of the tobacco and the mode of smoking in Turkey differ so much from the "shag" of England, and the mode of smoking in England and America, as possibly to account for the absence of tobacco amblyopia in Constantinople. Sir Henry Thompson says the ladies of Constantinople smoke fifty cigarettes a day, merely taking a few whiffs from each, and then throwing the cigarette away, and he considers little harm ensues from such smoking. To deny that tobacco produces amblyopia, because a large number of smokers escape, is as rational as to deny that small-pox can reproduce itself, because a large number of the exposed may escape the disease, or to deny that cold or wet can produce rheumatism, because so few of the exposed suffer.

ON TRACHELORRHAPHY—WITH CASES.*

BY DR. SKENE KEITH, EDINBURGH.

(Reported by Dr. H. Aubrey Husband.)

The operation for restoring a torn cervix uteri is not yet generally recognised in the southern part of this country, and some of the so-called Emmet's operations would greatly astonish the great American apostle of clipping and stitching. The few cases he had to relate brought out forcibly the necessity for following up the after history of the patients. He had heard of several cases who were no better some months after the operation, and who were supposed by the operator to have been cured, for example, he knew of a lady who a few months after the operation was no better but rather worse, as she was suffering from constant bloody discharge in addition to her other troubles. This discharge was accounted for by the presence of a wire suture in one lip and want of improvement by complete failure of union, yet it may have been put down as a cure as the patient did not see the operator after the first few weeks.

CASE I.—Mrs. G. had suffered for fifteen years from pain in both groins and from a constant aching in the region of the sacrum since the birth of her only child. The labor had been a natural one. After years of treatment she at last saw Prof. Skene, of Brooklyn, and was advised by him to have the cervix uteri repaired. The cervix was torn on both sides of the os, almost to the vagina,

and there was some, although not very marked, rolling out of the lips. The uterus was of normal size, and was not displaced. Dr. Skene allowed me to perform the operation and assisted me on the 21st December, 1881. Sims' speculum was used to bring the cervix into view in this and the other operations. After passing a sound I fixed on each lip of the cervix a double tenaculum at the spot where the centre of the external os was to be. With Skene's hawk-bill and Emmet's scissors I pared first the left and then the right side of the cervix leaving the central part untouched for the cervical canal. There was little hemorrhage. Three sutures were required on each side and after they had been tied up I passed a sound to be quite sure that the cervical canal was patent. This precaution is not altogether unnecessary, for I have since seen a cervix on which a so-called Emmet's operation had been performed, but where the menstrual discharges after the operation escaped through a small opening at the junction of the cervix with the vagina. There was retention of urine for twenty-four hours, and this was the only trouble the patient had after the operation. The sutures were removed on the seventh day, she sat up on the tenth, and at the end of a fortnight she came to Dr. Skene's office. The union was not as good as it might have been. However, the backache was quite gone, and the pain in the loins was not so bad. I have not heard of her since.

CASE II.—A lady, age 26, was seen by my father in April, 1882. Two years before she had been delivered of a seven month child with forceps, after having been in labor with convulsions for 48 hours. Since then she has suffered from constant backache and leucorrhœa. On examination with the speculum it was seen that the left side of the cervix was torn, and that the tear extended into the mucous membrane of the vagina. The right side was intact. The cavity of the uterus was increased to four inches, and there was no displacement. In May, 1882, I operated in the same way as in the previous case, except that one side only had to be repaired, and that two of the eight silk sutures which were required were entirely in the vaginal wall. After the stitches had been tied the tear measured two and a half inches. The patient had no trouble after the operation. On the ninth day two of the sutures about the centre of the line were found to have cut their way out. Injections

of hot water were given night and morning, and the other silk sutures were left in for two days more. Three weeks after the operation the cervix looked almost as though there had never been anything the matter with it. The uterus now measured two and a half inches. The backache and leucorrhœa had entirely disappeared. This lady kept perfectly well for seventeen months. She was then delivered of a child at term and since has had a slight return of the old trouble. A short time ago my father found that there was a slight tear anterior to the former one.

CASE III.—The patient, age 29, came under notice in March, 1882. She had at that time been suffering for four and a half years, since the birth of her only child, from backache and pain in the left groin. The labor had been a natural one. The backache has steadily increased, and more especially during the last twelve months. The cervix was hard, torn on the left side only. In July I operated. On account of the hardness and hypertrophy of the cervix I had to remove a thick slice of tissue before I was able to turn in the everted edges. The bleeding was rather free at first, but had quite ceased before I introduced the five sutures which were necessary to bring the parts nicely into position. The sutures were taken out on the ninth day, and on the eighteenth the patient went home. The line of union was very good, the backache was gone, and the pain in the left side was somewhat better. In December of same year the patient wrote to say that she had no pain and was cured. She kept well until six months ago, the leucorrhœa appeared accompanied with occasional pain in the side and back. Her doctor told her that she was much better for having had the operation done, so I suppose that the present illness is not due to my opening up of the cicatrix.

CASE IV.—Mrs. H., age 31, suffered from backache, pain in the groin, and leucorrhœa for ten months, since an abortion at about the fourth month. She had been a patient of Mr. Butler Smythe at the Grosvenor Hospital for Women and Children, Westminster, for a number of weeks, and had improved to a certain point, but could not be made to advance further by any of the usual treatment for such cases. When Mr. Smythe asked me to look at the case the cervix was torn on both sides, principally on the left, and the everted edges

were covered by exuberant granulations which bled easily. The uterine cavity measured two and a half inches, and the sound passed backwards with a slight curve. Mr. Smythe asked me to operate and I did so in April, 1883. There was no special difficulty in the operation. I was able to raw the right side with one snip of the hawk bill scissors, as the tear on that side was small and required but one suture; three were put in on the left. Patient suffered from no pain or disturbance after the operation. When she left the hospital the cervix looked beautiful. The leucorrhœa was quite stopped, the backache somewhat better, and the pain in the groin as bad as ever. Now she is perfectly well.

CASE V.—Mrs. M., age 36, has not felt well for years, and since the birth of her last child, seventeen months before I saw her, had suffered from constant backache and leucorrhœa, and frequently from facial neuralgia. On examination, the perineum was found to be partially torn, and what was left of it was lax and soft. There was a considerable rectocele, and this caused great straining at stool. The cervix was low down, large, hard, torn, and the lips were much everted, the posterior being fully twice as thick as the anterior. The uterus was slightly retroverted and the cavity measured three inches. In May, 1883, I pared and brought together the everted lips. There was some difficulty in doing this on account of the difference in the thickness. Six sutures in all were put in. At the same sitting I cured the rectocele by repairing the perineum. Five weeks after the operation the cervix could not have looked better. The patient went to the seaside, and although she came back looking very anæmic and not fully well, there had been no leucorrhœa or face-ache, and the back did not pain her as much as formerly. In December the backache began to get worse, and I found that my patient had become pregnant, and about one-third of the cicatrix in the cervix had given way. She aborted, and I again pared and brought together the everted edges, this time with wire. A week ago the patient wrote to say that she was feeling much better.

CASE VI.—Mrs. L., age 21, was well until after the birth of her second child, four years ago. After getting up she suffered from bearing-down pains, which were relieved by wearing a pessary. Six months ago she was delivered of a boy baby,

with forceps, and remained in bed for five weeks. Since then she has suffered from constant backache and pain in the left groin, and she has a profuse yellow discharge. When I saw the patient last November, the uterus lay low in the pelvis. The cervix was deeply torn on both sides, and there was a great deal of rolling out of the lips. The vagina contained a large amount of glairy mucus. After two months' treatment as an out-patient, during which time the cervix decreased in size the leucorrhœa got less. I thought that the tear would not improve further as it was an irregular one and I therefore operated. On the ninth day the patient felt perfectly well and had no pain. She went home at the end of three weeks, nursed her two children with measles, and her husband, who was also ill, and felt perfectly well for three months. Since then she had profuse discharge with pain in the stomach, and I have heard from Mr. Malcolm, who has been at the Samaritan Free Hospital, that there is considerable suppuration along the lines of the cicatrix on the right side, though the deeper parts appear to be quite firm.

REMARKS.—The operation of Emmet, when properly performed, is certainly of benefit in suitable cases, but I do not believe that it ought to be a very common one, for there are few women who have had a child without having their cervix uteri more or less injured, and most of these injuries do little harm. In my notes of a year's out-patient practice in the Samaritan Free Hospital, I found that I have marked down that there was a well-marked cervical tear in forty-two cases, yet in five only did I recommend operation and two of these five were on account of induration due to excessive application of caustics. Careful application of a mixture of carbolic acid and tincture of iodine with the hot douche and support of the uterus when necessary was found quite sufficient to heal up the other cases. Even in the Women's Hospital, New York, Emmet's operation is not a very common one. In four and a half months of the winter of 1881-2 I saw it performed there 24 times, and I was present at all the operations during that time. Trachelorrhaphy is not a very easy operation, at least, in most of the necessary cases, for in those the tissues of the cervix are much harder than natural. Where it is safe to draw the cervix entirely outside the vulva there would be little difficulty, but as this cannot be done I have found

that the most easy position is to have the cervix at its natural place at the upper part of the vagina, provided always that the patient is placed well in Sims' position and that the speculum is well held. There is far more room here than at any other part of the vagina. In forty cases I have but once seen hemorrhage of any intensity. In the others it either stopped before the stitches were introduced or after they had been brought together. I don't think that it is of importance what kind of sutures are used. In my next case I shall probably use wire for the crown ones, and silk, prepared according to Dr. Skene's method, for the uterus. The needles are of much greater importance. Dr. Emmet used round ones, but I don't find there is any objection to lancet-pointed needles, and certainly they go in much more easily. It is certainly a great comfort to fix into each lip a tenaculum of some sort, then one gets greater command over the cervix, and can keep it steadier than if a loop of thread or any other means be used.

Dr. Wilson congratulated Dr. Keith on his paper, and remarked that, considering the number of cases operated on the other side of the Atlantic, the midwifery must be somewhat rougher there than on this side.

Dr. Berry Hart did not understand the pathology of the cases operated on, and believed that some forms of inflammatory action went on in the parts. He would like to know the conditions Dr. Keith had met with in split cervix. He had seen pelvic cellulitis and other affections following the operation, and had heard many patients complain that they had not been benefited by the operation.

Dr. Milne Chapman had performed the operation with unfavorable results in four cases. He held that the tendency of Nature to heal the rupture in the cervix caused congestion of the part; this leads to a proliferation of epithelium, which prevented healing. In the one successful case a notable result was the diminution in sub-involved uterus.

Dr. Barbour had seen eight or ten cases; the benefit derived was only in about one-half of the cases. He, however, held that Emmet's operation was based on sound pathology.

Dr. Arnot (Bombay) thanked Dr. Keith for his paper, and was glad to hear a new operation discussed. He held that the proof of the success of the operation depended not so much upon a good

cicatrix, but on the results of a year's experience. How much of the temporary success of the operation depends on the local hemorrhage, relieving congestion, the rest in bed, etc., which accompanied the operation?

Dr. P. A. Young had had no experience of the operation. The operation, he held, received the almost universal assent of the profession. He related a case of chronic split cervix, which was cured by Emmet's operation.

Dr. Brewis recorded five cases treated by Dr. Angus Macdonald, four of which were successful. In the unsuccessful case there was shortening of the broad ligament, which prevented the cervix being drawn down, as was the custom with Dr. Macdonald. There was also some ovaritis. The case at first did well, but on the removal of the sutures it was found that the rent had not been improved. In two cases he had seen severe hemorrhage; he had used a styptic composed of iron, alum, and glycerine, but found the vagina charred, due to the styptic used. This should only be used in hemorrhage due to malignant disease. All cases should be watched by the nurse, as severe hemorrhage may come on in any case.

Dr. Webster mentioned a case in his practice where a severe split cervix had been cured by hot water.

Dr. Keith replied that he once held that the operation should be done far more frequently, but he had since modified that opinion. As to the pathology he had formulated no theory. He had operated more because he thought the cervix was at fault. He thought that the operation, as a rule, should not be done in cases of pelvic cellulitis. Dr. Emmet said that the pelvic cellulitis should be first carefully treated, and then the operation might be carefully done.

THOMSEN'S DISEASE.

TRANSLATION BY J. WORKMAN, M.D., TORONTO.

This is a muscular affection, which has been brought into notice by several German physicians and one or two French within the last few years. It has taken its name from the gentleman who, having himself been the subject of it, in common with a large number of his family stock, throughout five generations, was the first to treat of it with

clearness and precision. No less than thirty-five members of the Thomsen kin were known to have been affected with the disorder. Of thirteen children of his mother, seven were found to present it. Hereditary transmission would therefore seem to underlie this morbid form, and it is by no means improbable that it has not been exclusively confined to Germany and France, though, from its rarity and its apparent triviality, it may have failed to attract particular attention. The writer of this notice believes that he has seen, at least, one distinctly marked case in Canada, within the last two years, and it may be that the perusal of the following notice of an article by Longuet, in a *Revue critique*, in the *Gazette of Military Sanitation*, will lead some of the readers of the LANCET to recall some observances, which at the time of their occurrence wore an anomalous aspect.

The notice above-mentioned is presented in the *Revista Medico-Quirurgica* of Buenos Aires, for May, 1884, of which the following is a translation from the Spanish.

THE DISEASE OF THOMSEN.—In the critical review by Longuet, we have found the following historic details respecting the disease of Thomsen. The subject observed by Leyden was a discharged soldier, who was unable to open his fist when he had shut it; when reading, he was often unable to follow out the lines; the movements of his tongue were impeded; he could not dance or run. In the same year, 1876, Thomsen and Seeligmüller published the first two memoirs on the subject, which were remarkable for their clear and precise conception of the disease. Thomsen, who was not only an observer of the infirmity, but also a sufferer under it, and furnished the first description of it, has given origin to the name by which it is commonly designated in Germany. His own family presented several examples of it, coming down through five generations, in various degrees, and all presenting some form or other of neurotic character. Of thirteen of his mother's children, seven were affected with it. His own children also were affected, though in a mitigated form.

The case recorded by Seeligmüller was that of a recruit, who was a desperation to his drill instructors, because of the slowness and sluggishness of his motions, in spite of his own earnest desire, in the execution of the orders given him. At a later date, Peters, a surgeon major, published his obser-

vations of a soldier, 20 years old, who was affected similarly. At the command, "march," he remained immovable, as if rooted to the ground; afterwards, having moved his arms and legs disordinately, he succeeded in starting, but he vacillated for ten or twelve paces before he could attain free movement. He was absolutely unable to run, and if he persisted in the attempt he fell; his tongue and the maxillary muscles shared in the impotency; he could not raise his arms above the horizontal direction.

Westphal presented to the Medical Society of Berlin two patients, one of whom was a student of medicine and a nephew of Thomsen; he had been affected from his infancy. The symptoms are always the same; the functional anomaly may be presented in any of the muscles of the body. One of Westphal's cases showed that after sneezing, the patient could not again open his eyes without great effort, and when eating he could not always shut his mouth when he desired. The subjects of the affection have an athletic appearance, but their muscular force is only moderate. Westphal thinks there is a special congenital muscular perversion, coupled with an exaggerated muscular development.

Another recruit has recently attracted the attention of the assistant surgeon major Schonfield. This soldier was sent to hospital because, in his exercise, he suddenly fell to the ground, without any apparent cause. After a rest of ten minutes it was impossible for him to resume the march, at the word of command. He moved with great difficulty, and tottered and fell, rising again only with much difficulty. He had to proceed ten or twelve paces before he could move freely. When he sat down for any time, he could hardly rise again; the torpor, at such times, invaded the upper limbs, as the result of violent exercise. The speech was slow and drawling.

Mobins is the latest writer on the subject. He has published in *Schmidt's Jahrbücher* a very complete analytic review, having personally observed a young student of theology, who was a military volunteer, sent in by surgeon major Sane, who appeared to regard the case as a mimic form of the affection. This youth, after severe fatigue, suddenly became subject to cramps in the calves of his legs, and a stiffness of his limbs which left him powerless for many days. His father presented

the same defects, which were exasperated by the fatigues of military service. After a march, all his movements continued difficult for one or two days. Sometimes the loins were invaded, and after musket exercise, his arms, previously free from the trouble, became affected. The contracture is accompanied by a sensation of tumescence in the muscles attacked; but at other times by a sort of trepidation, like that from faradization; if the leg be extended, the whole limb enters into contracture, and remains for a time unable to bend.

A youth of 22, observed by Berger, presented in his exercise a torpor and rigidity which distracted his drill instructors. The French productions on this subject consist merely of the memoir by Ballet and Mare, published under the inspection of Charcot, and supplemented by a recent article of Mare's, who has given the following details of a case under his own observance. The subject, from early age, found that he had special difficulty in making any movement; when he was in class and was ordered to retire, he could not rise. When called into the army, he exhibited, under examination by the council of revision, the infirmity under which he labored; but the military surgeons did not believe in it; he was however set aside for two years, as of feeble constitution, at the close of which he was admitted. When he went to exercise, it was impossible for him to keep step with his comrades, and he had the like difficulty in managing his arms, as in attempting the motions he was seized with his contractures. The surgeon of his regiment declined to admit him as a patient, and he ordered him to the gymnasium to *soften him down*; but in these exercises also he was attacked with the cramps, and when, for example, he went to mount the wooden horse, he was seized in the moment of the effort, with muscular contracture, and he fell violently against the horse. There is no painful feeling in the muscular contraction.

It is not easy to account for this rare and curious infirmity. Does it consist in a lesion of the medulla, situate perhaps in the lateral cords, or is it a simple functional anomaly of the medullary apparatus? Should the affection be localized in the periphery of the nervous system, or in the muscles? All of these have been hypotheses advanced by different authors, but none of them appear satisfactory. Be it as it may, we have deemed it useful to call the attention of our colleagues to a

pathological curiosity which they may perhaps have opportunity to observe. It is well that we should know that a form of nervous disease exists, which consists in *initial transitory muscular spasm, probably hereditary, incurable and independent of any appreciable lesion of the nervous or muscular systems*. Such is the Disease of Thomsen, a designation now accepted both in France and elsewhere.—*La Gaceta de Sanidad Militar*.

THE MODERN OPERATION FOR CATARACT EXTRACTION, WITH CASES.

BY W. TOBIN, F.R.C.S.I., HALIFAX, N. S.

(Read before the Nova Scotia Medical Society.)

GENTLEMEN,—I propose bringing before this meeting the notes of some cases of cataract extraction, performed by myself, during the past two years, preceded by a description of the operation.

This operation, in each case, was what is known as the "combined modified linear extraction." It bids fair to become the favorite one with both English and continental surgeons. It consists essentially in an incision confined to corneal tissue, generally made upwards, combined with an iridectomy preceding the opening of the capsule. The instruments required are: a stop speculum—I prefer the one known as the Birmingham pattern,—a fixation forceps, one with a sliding catch being the best—De Wecker's; one of Graefe's narrow bladed knives, about five millimetres in breadth; an iridectomy forceps and scissors and a pricker, to divide the capsule. We may add a hard rubber spatula, also De Wecker's invention, to free the wound from tags of entangled iris or capsule.

The patient's eyes should have been examined, under atropine, some days previous to operation, if possible, and the nature of the cataract and its consistency ascertained; also the condition of the retina as to perception of light. The tension should also be noted and any history of previous inflammatory disease or errors of refraction. The eyelids should be freed, by appropriate treatment, from any pus-producing affection, such as Blepharitis (a frequent cause of flap infection). The steps of the operation are as follows: The patient is placed upon a bed or table with the head slightly raised. An assistant is required to administer chloroform—if an anæsthetic be given it is not

necessary—also to control the patient and to help with the iridectomy. The patient's lids and neighboring parts should be first washed with a disinfecting lotion. The operator's hands and his assistant's, the instruments and the water used, should also be rendered aseptic. It is advisable not to use sponges. A piece of absorbent cotton wool, moistened with boracic acid lotion, which may be discarded when soiled, answers every purpose.

The patient being fully under chloroform, we insert the speculum between the lids and secure it, Seizing a portion of the conjunctiva with our forceps, just below the vertical meridian of the cornea, we draw the globe downwards, and, entering the knife exactly at the sclero-corneal junction, at a point corresponding roughly to the upper margin of the pupil, we pass it slowly and steadily across the anterior chamber on a plane with the iris. Transfixing the opposite point, we carry the blade, with a sawing motion upwards and slightly forwards, making a flap whose summit should reach within a line or so of the corneal border. The assistant now takes the forceps whilst we seize a small portion of the iris and excise it. Resuming the fixation forceps, we pass in the pricker and divide the capsule, making a cross cut, which sometimes brings away a portion of it. Whilst we are doing so, and during the subsequent steps of the operation, the assistant raises and holds suspended over the globe the stop speculum. By pressing on the upper lip of the incision with the spatula and passing a similar instrument from below upwards along the cornea, we start the lens from its bed, and bring it into the lips of the wound, through which it is gently squeezed, perhaps losing some of its cortical matter in transit. The speculum is now withdrawn and the eye closed for a few minutes to allow the chamber to refill. By manipulating the upper lid over the globe surface, we collect the remaining cortical matter in the centre of the pupil, and, reopening the wound, by drawing the eye downwards, cause its escape in the gush of aqueous humor. It now only remains to free our incision from shreds of iris or capsule, with the spatula, to cleanse the globe and sulcus from clots, etc., and to apply the bandage.

I first place upon each eye a piece of lint soaked in boracic acid lotion, then fill up each orbit with layers of cotton wool and tie over all a Moorfield's bandage. This bandage is removed and the

dressings changed twelve hours after the operation, and is changed again twice a day for the first week. If all goes well it may then be discarded for a shade and protective glasses. I look at the operated eye (by oblique light, with a convex lens and a candle) on the second or third day. The patient is allowed to sit up after the first twenty-four hours; and to go out within the first ten days, should the weather permit it. The chief points in this operations as contrasted with the old flap extraction are: 1st, the antiseptic precautions; 2nd, the use of the narrow knife, which gives us great freedom in shaping our flap and allows us to correct a faulty incision even after penetrating the cornea; 3rd, by limiting our wound to the cornea, we get one which heals readily and we avoid a conjunctival flap, which by bleeding, etc., would interfere with the next steps of the operation; 4th, by doing an iridectomy, before opening the capsule, we free the iris from pressure during the escape of the lens, besides getting the undoubted prophylactic benefit of the operation—should we wish to be extra cautious the iridectomy may be done some weeks before-hand. 5th. The operation may be done without an anæsthetic—De Wecker never gives one, having once lost a patient under chloroform. The use of the spatula is also to be noted in cleansing the wound. Here eserine, as a pupil-contractor, may be also of service. Lastly I would draw your attention to our early examination of the wounded eye by non-irritating oblique light, and to the lessened confinement both to bed and to the house of our patient.

I enjoin a few cases illustrative of this method of operating.

CASE I.—Mrs. McC., aged 70, residence, Chester. Double senile cataract, complete in both eyes; a dyspeptic subject. Operated on right eye, assisted by Dr. Farrell. Made usual incision upwards. When about to extract the lens the patient showed signs of chloroform collapse. The operation had to be suspended till she was restored by artificial respiration and subcutaneous injections of brandy and ether. On recovery, the lens (hard, dark and small) came away easily. The eye was cleaned and the bandage adjusted. All went well till the sixth day, the patient then sitting up and using protective glasses. She incautiously removed them and a prolonged exposure to light brought on a sharp attack of iritis, with opacities

in the anterior chamber and vitreous. From this attack she made a tedious recovery. The treatment consisted in hot fomentations of belladonna and inunctions of mercurial ointment and belladonna extract with tonics and sedatives internally. However, in a month she was able to return home. The eye quieted down and the opacities were absorbed. Vision, which had been clear twelve hours after the operation, was restored, and she now sees fairly with the usual glasses.

CASE II.—Miss B., aged 55 years; residence, Halifax. Double senile cataract; complete in right eye, incomplete in left. An anterior synechia, the result of old iritis in the right. Operated upon the eye in Sept., 1883, assisted by Dr. Lawson. The usual corneal incision was made followed by a large iridectomy. The lens was found too large for the wound, which required a slight cut to free it. A portion of capsule adherent to the synechia obstructed the new pupil, but not seriously interfering with vision was allowed to remain. The bandages were removed within a week and recovery with good vision ensued without a bad eye symptom, though she suffered severely from rheumatism. She now sees well at a distance and can read with the usual glasses.

CASE III.—Mrs. C., aged 60; residence, Chester. Double senile cataract; mature in both eyes. Right some years, left one year. Can distinguish light from darkness. Operated on right eye 19th October, 1883, assisted by Surgeon-Major Orwin. Made the usual corneal incision, which in this case, however, was carried too far upwards, involving a conjunctival flap which bridged the incision (remaining uncut), bled freely, and obstructed the operation. In making the iridectomy the lens capsule was ruptured and the lens presented immediately. The conjunctival bridge was divided and the lens extracted; but from the incomplete division of the capsule this membrane had not retracted and occluded the pupil. An attempt was made to extract it with the forceps, but in doing so the posterior capsule was wounded, and there ensued a loss of vitreous. The wound was at once closed, and the eye was tied up with a compressive bandage. This was left unchanged for 48 hours up to which time there was no pain or uneasiness. The wound was then found healed and retained the aqueous. Pain followed, however, the reapplication of the bandage, and decided

iritis followed before the fifth day, shown by contracted pupil, haziness of anterior chamber, dimness of vision and pain over eyebrow. The iritis was treated in the usual way, by atropine instillations, hot fomentations of belladonna and mercurial inunctions, tonics and sedatives internally. In spite of all treatment, however, the pupil became contracted and updrawn, and when she left town, some six weeks afterwards, the eye was still irritable and vision was reduced to the counting of fingers. I have seen her quite lately (six months after the operation). The eye is quiet, the pupil V shaped and updrawn, but part of it is clear of capsule. She can find her way about the house, sees fairly at distance, and with glasses can read the large print of a newspaper. This case shows the troubles which follow a conjunctival flap. It also shows that it is better to leave the capsule behind, trusting to a secondary operation to clear it, rather than risk a loss of vitreous, by trying, injudiciously, to remove it.

CASE IV.—Mr. G., aged 62. Double senile cataract; mature in both eyes. A free liver who had suffered in his time from malaria. Operated on left eye on 21st April, 1884, assisted by Dr. T. Almon. The usual combined operation was done under chloroform, and the lens came away easily, on the end of the pricker. He suffered severely from pain, with great conjunctival inflammation during the first week, which I was at a loss to account for, till I found him considerably the worse for liquor, when visiting him with Dr. Almon, the sixth day after the operation. The eye became acutely inflamed, with chemosis, contracted pupil and dimness of vision. He was treated with solutions of boracic acid and atropine instillations. Stimulants (which had been allowed in moderation from the beginning) were withheld altogether, and a week after he was up and seeing clearly. I had a visit from him to-day (6th July) to fit him with glasses. The pupil is clear, key-hole in shape, and admits of good vision. With + 8 D. he sees well at distance ($V = \frac{2}{3}$ De Wecker's types), with + 14 D. he can read the smallest type in the text book.

CASE V.—Mr. D., aged 55; residence, Newfoundland. Double senile cataract; mature in both eyes, right eye one year, left 8 years. Operated on left on 4th June assisted by Dr. T. Almon. A small, low-placed corneal incision, such as that

recommended by Lubrech—done upwards and confined to the cornea. The lens on presenting was caught by upper section of wound. By pressing this down with the spatula it escaped easily. No other complication attended or followed the operation. On the 3rd day I examined the eye. The wound was healed and the cornea clear. On the 5th the bandages were removed, and a floating shade of black cloth replaced them. On the 8th he was allowed protective glasses and was able to leave the house, with the eye well guarded from light and dust, to take exercise. At the end of the month I fitted him with glasses. With + 8 D. vision= $\frac{2}{3}$ (reads De Wecker No. 7 at distance) with + 12 D. reads clearly newspaper type at 10 inches.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—The following questions have occurred to me in an hour or two of leisure, and are submitted for consideration, not that they present any new features, for undoubtedly every physician in ordinary practice has mentally asked the same, but to show some prevalent faults and to draw attention to matters pertaining to the welfare of our profession. Besides, it was thought that they would be a departure from the ordinary and monotonous style of medical reading so constantly subjected to our notice.

I. Why are there so many physicians engaged in other employments outside of their profession, who delight in a semi-philanthropic practice to the discouragement of others who endeavor to excel in, and who live solely by their profession?

II. Why are there so many among us who, in consideration of their length of practice, seem to deem it an honor to subscribe to the virtues of "Domestic Medicines," "Every Man his own Doctor," "Household Physician," and similar works?

III. Why is it that now and then a physician in good health, and doing (as he says) a \$3,000 or \$4,000 a year practice, will accept a position which brings in one-half or less of the above?

IV. Why do some Physician-Druggists allow themselves to act as vendors of such remedies as "Sir Jas. Clarke's" and "Lady Huntingdon's"

female pills, which are directed to be used with caution (?) at certain times?

V. Why do ministers of the gospel whom we, as a rule, attend without any pecuniary reward, whenever occasion presents itself at the bedside of one of their flock, interfere with the instructions of the physician, or tell about some similar cases wherein different treatment was beneficially used?

VI. Why is it that among these same reverend gentlemen there exist some who, without admitting any medical knowledge or having pursued medical studies, insult the regular profession with announcements of some specific "croup and diphtheria" compound, life saving pill or compound?

VII. Who is to blame for the ignorance existing among the public in regard to the distinction between patent medicines and well established therapeutical preparations, and where is there a man outside of the fraternity or drug business who understands why we prescribe Syr. Hypophosph. Co. (Fellows) and not "Dandelion Blood Purifier"?

VIII. Do our young physicians go to Europe for extra degrees or extra knowledge?

IX. Are not our nauseous and muddy mixtures advancing the interests of Homeopathy and the patent medicine business?

X. Why as a rule do many of our town and village brethren keep such filthy offices, filthy bottles of all sizes, colors, and shapes (pickle bottles are not uncommonly noticeable), when they know that neatness, cleanliness and order pay well?

"An' then a' doctors' saws and whittles
Of a' dimensions, shapes, an' mettles,
A' kind of boxes, mugs, an' bottles
He's sure to hae;
Their Latin names as fast he rattles
As A. B. C."

XI. Is there a physician of several years' practice who will deny the utility of a series of lectures to a graduating class pertaining to the ordinary duties and obligations of the profession to itself, and the public—and other minor details of a purely practical and business order, which so many of us have learned by sad experience and needless expense?

Yours, etc.,

QUEROR.

September 21st.

Reports of Societies.

HURON MEDICAL ASSOCIATION.

Oct. 7th, 1884.

Dr. Campbell, of Seaforth, presented a case of empyæma, in a boy 15 years of age, on which he had operated, first by aspiration, and after by free incision, removing, on the 29th May, six pints of sweet pus, and on the 12th June following, eight pints of foetid pus, by an incision three inches below the angle of the scapula. This was necessary on account of the distressing dyspnoea. Dr. C. was assisted by Dr. Elliott, of Brucefield. The treatment was, antiseptics locally, and syrup of the iodide of iron and Scott's emulsion constitutionally. Dr. C. also reported a case of puerperal eclampsia at eight months. Labor was induced, and delivery by forceps. The convulsions increased in frequency and violence until one-fourth of a grain of pilocarpine was injected hypodermically the second time, when recovery took place.

Drs. Gunn & Elliott presented a case of cirrhosis of the liver in a man 63 years of age. About two months ago he vomited nearly two quarts of blood and has not been well since. The question of cirrhosis was discussed, some thinking that it might be cancer of the stomach. The spleen, on percussion, appeared to be enlarged, and an incurable eczematous eruption covered his chest and face. Drs. G. and E. also showed a case of peculiar nervous hiccough connected with absence of menstruation, which has been in progress about four months, during three of which considerable vomiting was present. The hiccough is constant except when sleeping, and amounts to from 60 to 100 hiccoughs per minute.

Dr. Williams presented a case of blindness of both eyes from congestive amaurosis. The left eye became blind three years ago, and in the last week the other eye became blind in about three days.

Dr. Nichol, Bayfield, read a very interesting report of a case of traumatic tetanus, terminating fatally, produced by a gunshot wound of the thigh. The charge of shot had been in the wound three weeks when he first saw the patient, and tetanus had existed four days without treatment. The probe passed its whole length, and a counter opening was made to facilitate discharge. Any manipula-

tion of the wound at once produced a spasm. He died on the eighth day, twelve days after the tetanus began, and thirty-three days after the accident. Chloral hydrate appeared to be the only remedy that controlled the spasms. The question arose as to whether the charge of shot could not have been extracted and the young man's life saved. At the post mortem the charge was found a little beyond where the probe had reached, and a little perseverance in the early part of the difficulty might have found and extracted the shot by a counter incision.

Dr. Worthington, of Clinton, showed a case of compound fracture of the third metacarpal bone of the right hand, produced by a dull adze, the finger being shortened one-fourth of an inch. A method of extension was devised, and the wound was treated with boracic acid gauze. The wound united by first intention, and the patient suffered no pain from the first.

Some cases of ulceration of the leg were shown after typhoid fever, and a peculiar case of eczematous inflammation of the leg of long standing.

Selected Articles.

THE YEO RESPIRATOR.

Dr. S. Cohen, M.D., of Philadelphia, gives the following in the *Medical News*, Oct. 11th:—

Continuous inhalation of a volatile medicament by means of an apparatus worn over the nose and mouth—a so-called "*respirator*"—is by no means a novel idea; but the cost and clumsiness of most of the appliances devised for the purpose have until recently prevented this method of treatment from being carried out upon a sufficiently extended scale to afford a reliable test of its efficiency. Dr. I. Burney Yeo, of London, described and figured in the *British Medical Journal*, for July 1, 1882, a respirator constructed of perforated zinc bound with chamois skin, shaped to cover both nose and mouth, which carries a sponge upon which the medicament desired to be inhaled can be dropped, and which is retained in position by means of a pair of elastic loops passed around the ears. The lightness of this appliance, its cheapness, and its cleanliness, commend it as the best device for the purpose yet offered to the profession. Until within a few months it has been impossible to obtain the respirators in this country, and those used in the cases upon which this article is based, were imported. Messrs. Wyeth & Bro., of this city, are now manufacturing them, however, with a slight

change in style suggested by Dr. J. Solis Cohen. This modification consists in placing the sponge within a little cage formed by a fold of zinc in the front of the respirator, instead of retaining it in position by elastic bands.

The material of which the respirator is made being pliable, it can be accurately fitted to the face. The shape being adjusted, the sponge is wetted with hot or boiling water, and the medicament dropped upon it. The respirator is then fastened around the ears, and worn for such period as may be directed by the physician, or practicable for the patient. In many cases, the patient being engaged in his business occupations during the day, will consent to wear the respirator at night only. Some patients can sleep in them, others find it impossible to do so. The following are the substances



recommended by Dr. Yeo for inhalation ; creasote, liquefied carbolic acid, spirits of turpentine, eucalyptus oil, terebene, spirits of camphor, solution of tar in rectified spirit, tincture of benzoin, and tincture of iodine. He uses of these five minims, either alone or mixed with an equal quantity of spirits of chloroform. Of course, any drug volatile at ordinary temperatures can be employed, but the list given by Dr. Yeo embraces nearly all which have been found of value in daily practice. I would add to it, however, chloroform, iodide of ethyl, and the alcoholic solutions of thymol and of menthol. Dr. Yeo's principal resort to treatment by the respirator has been in cases of phthisis, in which he has desired to keep up a continuous antiseptic inhalation ; and the drug which he has found of the most service is creasote. From this treatment, in conjunction with proper hygienic measures and constitutional medication, he has obtained excellent results, some of which he has reported.

Dr. J. S. Cohen and myself have tested the method during the past two years at the German

Hospital, at the Philadelphia Polyclinic, and in private practice. The cases selected for this purpose number more than one hundred and fifty. While our results do not justify the endorsement of the plan as in any sense curative of phthisis, they have convinced us that much comfort may be afforded to patients past cure ; that distressing symptoms may be quickly relieved, and in some instances entirely removed ; and that recovery may be aided in cases affording reasonable basis for favorable prognosis. In other diseases of the respiratory organs, there has seemed to be a hastening of the favorable termination in some instances, and a marked degree of relief in others, even in chronic and incurable affections. Without detailing histories of cases the following general results may be recorded :

In Phthisis.—In cases with slight laryngeal involvement, the inhalation of terebene (ten drops, renewed every second or third hour) as continuously as possible during the day, with the addition of chloroform (five drops at bedtime) during the night, has seemed to allay the uncomfortable sensations of dryness and heat in the throat, and to restrain irritative cough. The relief has been particularly marked, and the gratitude of patients correspondingly great in cases in which, prior to the institution of treatment, sleep had been disturbed by violent spells of coughing two or three times during the night. In those cases in which the absence of a hemorrhagic tendency has permitted the use of daily inhalations of compressed air, after the increased coughing and expectoration caused by the loosening of retained and impacted secretions has subsided, there has been almost entire cessation of coughing. At most, in some instances, there has been a "clearing out" cough on arising in the morning, and in but one or two instances has an unproductive cough remained during the day or night. In dispensary practice, oil of turpentine (twenty drops) has been prescribed instead of the terebene, with almost equally satisfactory results. In some cases, however, especially those in which there has been organic lesion or functional disturbance of the kidneys, terebene and turpentine have caused distressing symptoms referred to the back of the head and to the ears, and apparently due to cerebral congestion. Many patients, even among those whose disease has already proved fatal, have declared that they could not be induced to part with "the little machine." In one case, which I shall at some future time report in full, the patient, a girl of eighteen years, complained that the dose of chloroform (three minims) ordered at bedtime, "smothered her." On increasing the dose to five minims, the unpleasant sensations disappeared, and she fell almost immediately, upon retiring, into a refreshing sleep, undisturbed by the cough that had formerly harassed her throughout the night. While it is only fair to add that in this

case there was a constant and remarkable improvement in every respect under constitutional treatment, yet the relief to cough preceded other favorable changes.

In cases with marked laryngeal disease, the amelioration produced by treatment with the respirator, while decided, has not been so great as in the preceding group of cases. These patients have, as a rule, done better under creasote than under terebene; and where there has been extensive ulceration, eucalyptol seems to have done more good than either of the other drugs. Eucalyptol, however, has been on the whole a very disappointing and unreliable drug, failing utterly in some instances, and as yet, without affording any positive indications as to the conditions in which it is likely to prove of service. Whatever drug has been employed in this group of cases, whether terebene, turpentine, thymol, creasote, or eucalyptol, the best results have been obtained from its admixture with chloroform or with spirits of chloroform; chloroform alone being used at night.

In Bronchitis.—In subacute and in chronic bronchitis, good results have been obtained from the use of the Yeo respirator, worn for an hour or two at a time, during the day and night, with terebene, spirits of turpentine, or tincture of benzoin, as the medicament. In bronchorrhœa and in fetid bronchitis, creasote and carbolic acid have been advantageously employed, either singly or in connection with one of the other remedies. Eucalyptol has been of value in a few cases. Ethyl iodide has given excellent results in cases of profuse bronchorrhœa. Even in a few instances of pulmonary gangrene, the fetor has been controlled by this drug, after failure of other remedies. In most instances, cough has been restrained and expectoration has been diminished in amount and corrected in character; while the subjective relief afforded has often been most gratifying.

In Chronic Laryngitis and Tracheitis.—In cases of chronic laryngitis in which burning or tickling sensations in the throat, or annoying cough, have constituted sources of distress, terebene, creasote, camphor, and tincture of benzoin have proved very useful. Eucalyptol has succeeded where the other remedies have not answered a good purpose; but has not been at all reliable. It must be used, if at all, in small quantity (two or three minims on the sponge at a time) or well diluted. The benefit of inhalation by means of the respirator has been most marked in cases of laryngo-tracheitis characterized by a constant desire to hawk out something that seems to stick in the upper part of the trachea; a purely subjective sensation. In these cases terebene has been chiefly used, but tar has also seemed to be beneficial.

FIBROID TUMORS—DYSMENORRHOEA—RAPID DILATATION.

CLINIC BY DR. GOODELL.

GENTLEMEN :—The first case is one which comes for diagnosis. The patient is a colored woman, 45 years of age, who has been married sixteen years, and had seven children, the youngest of which is five years old. She has not seen the menses for over one month. Previous to this they had been coming every two weeks, and were profuse. If she were an unmarried woman, or married and sterile, I should say that she either had a fibroid tumor or a polypus. But as she is a married woman and has children, then I would say, if she were white, that most likely she had carcinoma. On the other hand, she is a colored woman, and I have never yet seen carcinoma of the neck of the womb in a colored woman. We therefore come to the conclusion that she has some growth which causes the bleeding. The diagnosis lies between the rare disease of cancer and fibroid tumor. It is true that the bleeding might be due to fungous vegetations, but usually these do not cause bleeding every two weeks. They produce menorrhagia, with a profuse leucorrhœa between the periods. It might be a malignant growth within the cavity of the womb, but this is rare.

We shall now make the vaginal examination. The womb is decidedly larger than it should be, and on its posterior surface I feel a number of disseminated nodules. This is evidently a case of multiple fibroids. I had expected to find a tumor of some magnitude. The sound gives a measurement of 3.5 inches. I can feel the left ovary, which is hard, enlarged, roughened, and hardened. This is interstitial or parenchymatous degeneration, the result of ovaritis, and is not uncommon. I have never seen but one ovarian tumor in a colored woman, and that was in a mulatto. I can touch without much difficulty the promontory of the sacrum. She states that all the labors were hard, but that instruments were only used in the next to the last labor, and that all her children were very large. I can trace the sacrum all the way from the coccyx to the promontory. When you can touch the promontory of the sacrum with the finger, you may be sure that the pelvis is contracted. The promontory can be reached more readily in those cases in which the perineum is relaxed or torn. In this case the perineum is torn down to the sphincter.

Here is a woman whose womb measures three and a half inches, who has fibroid nodules in the posterior wall of the uterus, and also a laceration of the perineum. This latter, however, is not sufficient to demand the operation. She is not suffering enough to demand the operation. The change of life is coming on, and the nodules are not large

enough to warrant the idea that she is going to lose much blood. There has been an interval of a month since the last period, and perhaps the next may be longer than a month. We shall order for her ten grains of chloride of ammonium, and twenty drops of fluid extract of ergot three times a day. She will return in the course of a month, and report results.

The immunity of the colored race from cancer of the uterus is rather remarkable. Some of the southern physicians say that they have seen cancer in the colored race, but not so commonly as among the white race. They have another form of disease which the whites rarely have, that is keloid disease of the skin. I have seen this a number of times in colored people, but only once in the white race. Colored women are, however very subject to fibroid tumors of the uterus. It is rare to find a fibroid tumor in a white woman before the age of thirty-five years, but in sterile colored women from the age of twenty to thirty-five, they will be found quite frequently. These tumors do not cause death, although a physician who sees a great many of these cases has to operate occasionally. In a case which I saw the other day, I found a fibroid tumor as large as a man's head in an unmarried woman of thirty-nine. She is losing a great deal of blood, it is an anxious question to decide what is best to be done. Her physician states that during the past few months it has been growing rapidly. Now a fibroid tumor which increases rapidly in size may become so large as to interfere with any operation.

In operating for fibroid tumor of the uterus an exploratory incision is made, and if the tumor is found to have a pedicle, this is tied and the tumor removed and the wound closed, just as in the removal of an ovarian tumor; and this ought to be as successful an operation as removal of ovarian tumors. It is, however rare to find a fibroid tumor with a pedicle. They usually spring directly from the womb. When this is the case, the proper plan is to remove the ovaries, which is a simple operation. By so doing, not only is menstruation stopped, but large blood vessels passing to the uterus are ligated, and in this way the blood supply is to a great extent shut off from the tumor, and in the great majority of cases it will diminish greatly in size. I have performed the operation a number of times, and have failed to check the hemorrhage in only one instance, and in this case the tumor proved to be malignant. If the tumor is allowed to become too large, it may render the operation impossible. Two years ago I operated on an enormous fibroid tumor in a white woman of thirty. I had seen her a year previously and had urged the operation, but she preferred to wait. At the time of the operation the tumor filled the abdominal cavity, and must have weighed forty pounds. I had to make the incision from the ensiform cartil-

age to the symphysis in order to get the tumor out of the abdomen. The ovaries were attached to the tumor, and one of them was stretched to a length of six inches. It was a very serious operation, and the girl died in forty-eight hours. I have always regretted that I did not remove the womb in that case, although the result might have been the same. When the tumor is not large, it is possible to get at the ovaries without much difficulty. In these cases the ovaries and Fallopian tubes will as a rule, be found to be diseased. Very often the tubes are cystic. When the ovary is affected it is often a follicular degeneration in which the capsule is thickened and the follicles are enlarged and project from the surface, or else an interstitial degeneration in which the organ is enlarged, roughened, and hardened, cirrhotic in character.

DYSMENORRHOEA : RAPID DILATATION.

Here is a patient thirty-one years of age, married and sterile, who has had a great deal of pain since the time of puberty. This has been so bad as to incapacitate her for work, and it has been growing worse and worse. Why should she have pain, and why should it grow worse? If an unmarried woman, or a woman who is married and sterile, comes to you with a history of dysmenorrhœa, what should pass through your mind? That it is a dysmenorrhœa from ante flexion; that it is due to a stenosis caused by the womb bending too sharply towards the front—towards the front because she has never born children, and the natural position is slight ante flexion. This is an exaggerated condition. There are very few exceptions to this rule. Sometimes there is retro flexion. As a rule, you will find ante flexion. The dysmenorrhœa is mechanical, and usually gets worse after marriage. The woman may have been able to get along pretty comfortably before marriage, but afterwards the pain becomes worse and worse. Nature intended that when a woman got married she should become pregnant, and if a married woman does not have children, she nearly always suffers. The pain of dysmenorrhœa, due to stenosis, is usually of that character. It gradually becomes worse until it culminates, and when it reaches the highest point, there is a sudden gush and the pain subsides. Then it begins again and reaches another culmination, which is followed by a gush and relief. The womb is bent. The menstrual blood tries to overcome the bend, but it cannot do so until it has straightened the womb. After the womb is sufficiently distended to remove the bent condition of its neck, there is a sudden gush of fluid followed by relief. The same thing is seen when a rubber tube is bent; the water flows through the tube until it reaches the bent portion, when it is arrested until the force behind becomes sufficient to straighten the bend, and thus overcome the obstruction. The pain is due, not only to distension of the womb, but also

to the efforts of the organ to force the blood out of its cavity. This causes thickening of the endometrium, which in turn tends to increase the difficulty. When a woman suffering with this form of dysmenorrhœa gets married and does not bear children, the congestions arising from sexual intercourse will cause greater thickening and hypertrophy of the lining membrane of the womb, and consequently the cervical canal becomes still more contracted. There is not only thickening of the endometrium, but also hypertrophy of the parenchymatous structure of the womb. Then there is congestion of the ovaries and structural changes following on this congestion. These changes may either result in follicular or interstitial degeneration.

I shall now make a physical examination. The first thing I detect is a virginal cervix. It is not thicker than my little finger. The os is very small. With a little manipulation, I get the sound past the bend and obtain the measurement of three and a quarter inches. This increased length of the womb has been produced by the dysmenorrhœa. I propose to operate for this trouble by forcibly dilating the neck of the womb. The cutting operation is the one usually recommended in the books, but that is a dangerous operation, and is by no means as successful as forcible dilatation. I have notes of one hundred and fifty cases in which I have performed this operation, and there has not been one fatal result, and in but one or two has there been any pelvic inflammation. To show you the result of the operation, let me refer you to a case on which I operated a number of years ago. A clergyman's wife came to me suffering greatly with dysmenorrhœa. She had been married several years, and was sterile. I dilated the canal and heard no more of the case until a few days ago, when I saw her physician who told me that after the operation she had gone home, and the first year had twins and has been having children ever since. I have had a number of such cases, in which pregnancy followed the operation. In the majority of cases, it is not necessary to perform the operation more than once, provided it is done thoroughly under ether. Women often object to taking ether, and want me to do it in my office without ether. I always tell such patients that the operation gives a great deal of pain, has to be repeated frequently, and is very imperfectly performed under such circumstances. I tell them of the man who had a dog of which he was very fond. The dog had a long tail greatly disfiguring him. The tail had to be cut off, but the owner of the dog disliked to give the dog so much pain—he therefore concluded to take off an inch a day until a sufficient length had been removed.

I shall first take this Ellinger's dilator and tunnel my way into the womb. First, introducing the dilator as far as it will go and dilating to that point, then pushing it a little farther, I again dilate, and

in a few minutes the instrument passes the internal os. Sometimes when the os is too small to admit the entrance of the dilator, I enlarge it with the scissors, keeping the blades closed, and using them with a boring motion. As I remove the dilator, you observe that a quantity of thick mucous follows its withdrawal. Whenever this is seen it is an evidence of obstruction. I shall now introduce the larger Wilson's dilator. In buying a dilator of this kind, you should be sure to see that it has these little shoulders on the blades to prevent it from slipping too far into the uterus; for if the blades should come in contact with the fundus of the womb and be separated in that position, there would be risk of producing serious injury. After dilating up to a certain point, I wait a while. In all the cervices that I have dilated, I have torn only two. One was in a virgin and produced a slight laceration. The other was in a case which had been treated by the application of nitrate of silver until the tissues had been made brittle by the formation of cicatricial tissue. In that case a slight laceration was produced, and the bleeding was free enough to require the application of Monsel's solution. That is the only case in which I found it necessary to apply any styptic. Sometimes I get hold of a very small cervix, one which is really infantile. Under such circumstances I do not expand the instrument to its fullest capacity, for fear that I may tear the cervix. In the majority of cases, however, I dilate to the fullest extent of the instrument. This gives an os through which the finger may be passed to examine the interior of the womb, and in many cases this is better than dilating with sponge tents. There is not the same danger as exists with sponge tents. On the other hand, tents will dilate to a greater extent. After a dilatation of this kind I can often introduce my finger into the womb, although I am not usually able to do so in sterile cases. I have now separated the blades of the dilator to their fullest extent. I shall remove the ether and allow the instrument to remain until the woman begins to flinch. Just before beginning the operation, I introduce a suppository of one grain of the aqueous extract of opium into the rectum, so that by the time the operation is completed the suppository will have dissolved and the opium be absorbed. At first the pain is great, but it soon subsides. Usually two suppositories are all that is required, one being given at the time of operating, the other two hours afterwards. If the pain continues, the opiate must be repeated. If there is much soreness, I have a poultice placed over the abdomen. I always like to keep these patients in bed for forty-eight hours. For the first twenty-four hours I order a light diet, and after that the patient returns to her ordinary food. If the soreness continues, I keep them in bed until it disappears. The woman is now beginning to show evidence of feeling the pain, and I

shall remove the dilator. It is very probable that some of the muscular fibres have been ruptured. I know that some of them have been over-stretched and will never contract as before. There is, as you see, a little oozing of blood, but I shall not attempt to check this, for I consider a little bleeding an advantage, as it tends to prevent the occurrence of inflammation. I have never had severe metritis or peritonitis after this operation. I have, however, seen slight localized inflammation follow it.

You will often be consulted by sterile women who want to have children. It is a mania with them. If a woman wants to have children, she will go through fire and water to become pregnant; and on the other hand, if she does not want to have children, which I am sorry to say is the crying evil of the day, she will go through fire and water to prevent conception. If a woman wants children, all her friends know of it. Sometimes this operation will enable such a woman to become pregnant. At times, however, the condition has lasted so long that changes in the uterus have been induced which effectually prevent conception. If you are fortunate enough to enable her to have children, she will blazon your name and skill all over the neighborhood. If this operation is done carefully, I can recommend it most confidently. It is much safer and far more successful than the cutting operation, which I am happy to say is now rarely performed.—*Med. and Surg. Reporter.*

WOUNDS OF THE INTESTINE—GROSS.

* * The diagnosis of wounds of the bowel is a matter of primary consideration, as upon its prompt determination the success of our treatment must mainly hinge. The possibility of this will, of course, mainly depend upon the situation in which the bowel is found at the time of the accident. If it has escaped through the wall of the abdomen it will generally be easy to find the injured part by the egress of some of its contents, as feces, mucus, or bile, or all these together; and so also when there is a discharge of some, or all, of these substances through the outer wound, although there be no protrusion of the intestine. The coast in both of these conditions is sufficiently clear; so clear, indeed, that he who runs may read and accurately interpret. But it is altogether different when the abdomen has been pierced with a narrow instrument, as a knife or a dirk, or perforated by a bullet. In such an event the bowel does not protrude, and hence the true nature of the case must be solely a matter of conjecture. All that is positively certain in such event is that there is a wound in the wall of the abdomen. The surgeon, especially if called immediately or soon after the receipt of the injury, must be in doubt whether the weapon has entered the bowel or not. In reflect-

ing upon the subject he recalls the fact that a bullet, a rapier, a sword, or a ramrod has occasionally passed through the abdomen, and, perhaps, even emerged at the opposite side, without in the slightest degree interfering with any of its contents. The records of surgery furnish many such cases.

The two principal signs which must serve to guide us in these uncertain cases are tympanites and a discharge of blood by the anus. The occurrence of tympanites is unquestionably a symptom of great value. Jobert, who was the first to notice it, regards it as the most reliable of all the phenomena when there is no escape of feces, mucus, bile, or other fluid at the abdominal wound, and in this opinion the results of my personal observation fully coincide. The tympanites supervenes at various periods; sometimes almost immediately after the wound in the bowel has been received, and is then always of proportionate diagnostic value; at other times it supervenes very gradually, and in some cases, again, it does not make its appearance under twenty-four, thirty, or thirty-six hours. However this may be, it is always diffused, not circumscribed, and sometimes reaches an enormous height, the belly emitting a hollow, drum-like sound on percussion, and is then always very painful.

Although tympanites is generally present in lesions of this kind, there are cases in which it is entirely absent; as, for example, when the wound in the bowel amounts to a mere puncture, in which the opening is effectually closed by the protrusion of the mucous membrane, thereby preventing all escape of gas into the peritoneal cavity.

A discharge of blood by the anus I regard as a very valuable symptom of the existence of a wound in the bowel. It is especially valuable when it makes its appearance within a short time after the infliction of the external wound, and when it continues, more or less abundantly, for some days afterwards. As the blood is always intermixed with the contents of the bowels, it seldom comes away in a pure state, but is generally of a dark color, and of a grumous consistence.

No useful conclusions can be deduced from the shock and the pain which attend lesions of this character, since both vary greatly in different cases and in different circumstances, some persons suffering very little, while others, owing to the peculiarities of their nervous endowments, experience extreme distress.

In regard to probing wounds of this kind, the universal sentiment of the profession is opposed to it, on the ground that, while it can do no good, it would often be productive of great harm, by disturbing the relation of parts, and thus endangering fecal effusion. I do not think, however, that this rule should apply to the mural wound. Here a probe, properly used, might at least afford useful

information in regard to the direction and extent of the external injury.

In the treatment of wounds of the intestines two leading indications are scrupulously to be kept in view—the prevention of fecal effusion, and occurrence of peritonitis. To secure the first, the only safeguard is efficient suturing of the wound. A case, it is true, occasionally recovers without any precaution of this kind, but this is owing to good luck rather than to good treatment. The question here naturally arises, should all wounds of the bowel, however small, be sutured? Upon this subject there was certainly till recently, if indeed there is not still, some diversity of opinion. Dionis, Palfin, Heister, and Sabatier state that enterorrhaphy is unnecessary when the wound does not exceed the diameter of a goose-quill or a penknife; and views of a similar nature are to be found in other writers, as Sharp, Richerand, Boyer, and Jobert. On the other hand, there are surgeons who are opposed to the return of the bowel into the peritoneal cavity, however small the intestinal wound, without the employment of sutures, lest fecal extravasation should ensue. The great Benjamin Bell, of Edinburgh, writing near the close of the last century, holds, in the midst of the darkness that surrounded him, the following emphatic language: "However small a wound of the intestine may be, it ought always to be secured with ligature; for, although it is alleged by some that we should rather trust to nature for the cure of a small opening than to insert a ligature, to me it appears that the opinion is by no means well founded, inasmuch that I would not leave even the smallest opening, that could admit either *fæces* or chyle to pass, without stitching it up. Much danger may ensue from omitting it, and the hazard of the patient cannot be increased by the practice being adopted." This advice of the sagacious Scotchman, so clearly and emphatically enunciated nearly a century ago, is now the universal practice in all cases of wounds of the bowel, however diminutive, based as it is upon the well-ascertained fact that enterorrhaphy, when properly performed, is a harmless operation as compared with the risk of fecal extravasation and the consequent certainty of peritonitis.

Judging from the results of my own observations, I have long been of the opinion that there are only two sutures that should ever be employed in sewing up a wounded bowel. These are the continued and interrupted, with the modifications of the latter by Lembert and Gély. As to Jobert's method, which consists in invaginating the ends of the bowel, when completely cut across, so as to place the two serous surfaces in immediate contact, to facilitate their prompt union, the operation is not only extremely difficult, but very liable, even if successful, to be followed by more or less contraction of the tube at the seat of the injury, thereby

interfering more or less seriously with the transmission of its contents.

The interrupted suture is, as a rule, preferable to the continued, in all wounds of the bowel, whatever their extent or direction, whether they embrace the entire calibre of the tube or only a limited portion, and whether they are circular, oblique, or longitudinal. The operation executed with a long, slender sewing-needle armed with a thin, but strong, well waxed silk thread, is comparatively simple, affords ample security against fecal effusion, and is never followed by injurious contraction of the tube. The sutures should be placed not more than one line and a half, or the eighth of an inch, apart, and the ends, tied in a double knot, should be cut off close, so that in time the sutures may find their way into the bowel and be discharged along with its contents. I deem it very important that each suture should be fully one line from the edge of the wound, and that the needle should be passed deeply through the wall of the bowel instead of embracing its entire thickness—an arrangement which would almost inevitably be followed by more or less puckering, and by the consequent retardation of the cure. The operation of uniting the bowel where the division is complete, will be greatly facilitated if the first suture be inserted at the mesentery and the second immediately opposite. The best, certainly the safest, ligature for suturing a wounded intestine is ordinary sewing *silk*, well waxed, and inserted with a long, sharp sewing-needle. The carbolized catgut ligature is liable to give way prematurely, and should, therefore, be avoided.

In the modification of this suture by Lembert, the object is to invert the edges of the wound so as to bring the two serous surfaces in immediate and firm contact, to establish, as it were, union by the first intention. Great advantage has been claimed for this form of suture, but this is not so apparent when it is remembered that, unless great care be taken in introducing it is liable to be followed by more or less contraction of the tube. In making this suture the needle makes two dips on each side of the wound instead of one, as in the ordinary procedure.

"Gély's suture, which is merely a modification of that of Lembert's, is made with two needles inserted near the angle of the wound, about one line from its edge; they are then carried along the interior of the bowel, parallel with the wound, for the sixth of an inch, when they are brought out precisely at the same level, so as to appear again on the peritoneal surface. The threads are then crossed, the right needle being passed through the puncture made by the left, and conversely, when the ends are firmly tied and cut off close, as in the ordinary operation. The number of sutures varies, of course, according to the extent of the cut. In this way the edges of the wound are thoroughly in-

verted, and consequently all danger of fecal effusion is prevented: the coaptation, in fact, is so accurate as to conceal the ligatures.

The treatment of wounds of bowel by the continued suture has afforded good results in my experiments upon dogs. The chief objection to it is that it leaves the edges of the wound in an uneven, puckered condition, which interferes, perhaps, somewhat with rapid union. This, however, may be prevented in great degree, if not wholly, by the employment of a double thread, after the fashion of the glover, although I do not consider this at all essential to success. Of the seventeen experiments performed with a single ligature, not one terminated fatally. The wounds in two of the cases were transverse, oblique in three, and longitudinal in twelve. The wound in one of the latter was six inches in length. The dog, a large, old one, was killed on the twentieth day, when every trace of suture had disappeared, with the full restoration of the calibre of the tube. I must not omit to state that in all these experiments the sutures were passed through the fibrous tunic of the bowel, or, in other words, outside the mucous membrane. We have here, then, also a very valuable suture for sewing up wounds of the intestines, especially well adapted to the treatment of longitudinal and oblique wounds; not so well, I think, to the treatment of transverse ones as the interrupted.

The suturing of the wound having been completed, and any foreign substance that may be present removed, the bowel is restored to its natural situation, followed by the omentum, in the event of its prolapse. It is hardly necessary to say that the protruded structures should be treated in the most gentle manner; any wiping that may be required should be performed with the softest cloth, and all firmly adherent matter should be picked off with the forceps. Generally speaking, the best way of cleaning the parts is to make free use of the syringe, charged with warm water. The operation may be completed with a one to one thousand solution of corrosive sublimate. The return of the bowel will be materially facilitated by the use of a little olive oil. If any serious obstacle offer, it must be surmounted with the probe-pointed bistoury, or by puncture of the tube, if it depend upon the presence of gas. The wound in the wall of the abdomen should be closed in the same manner as in ovariectomy, the sutures being carried through the peritoneum so as to protect the parts effectually against hernial protrusion, a thing never to be lost sight of after such lesions.

The question arises here, What should be the conduct of the surgeon when the bowel is wounded; but not prolapsed, owing to the small size of the mural opening? I do not think I can answer this question better to-day than I did forty years ago, when we knew comparatively little of abdominal

surgery, and when the most visionary enthusiast could not have dreamed of half the triumphs that have since awaited it. The case in question is a suppositious one, and is thus stated: "A man, after having indulged in a hearty repast, receives a penetrating wound in the abdomen from the thrust of a dirk or knife; the bowel is pierced, or it may be, nearly divided, and there is a copious discharge of fecal matter, both externally and into the peritoneal cavity, as is evinced in the latter event by the excruciating pain, the gastric oppression, and the collapsed condition of the sufferer. Here the most prompt and decisive measures must be resorted to, or the person will perish from peritoneal inflammation, with as much certainty as if his skull had been fractured and a portion of his brain had been let out. It will not do for the surgeon to fold his arms, and look upon the scene as an idle and disinterested spectator. Far otherwise; he has a duty to perform, and that duty consists in dilating the external wound, if it be not already sufficiently large, in hooking up the injured bowel, and in closing the solution of continuity with the requisite number of stitches, at the same time that the effused matter is carefully removed with tepid water and a soft sponge. All wiping must, of course, be carefully avoided, as this would add much to the risk of peritonitis.

It is a rule with all educated surgeons to do the work which they are called upon to perform in as complete and thorough a manner as possible, and nowhere is this precept of greater importance than in the treatment of wounds of the intestines. A case recently reported by Professor O. K. Roberts, of Louisville, Ky., will aid me in illustrating my meaning. A man was cut in the abdomen with a pocket-knife; the wound was three inches long; the bowel protruded, and was pierced at two points, one opening being of the size of a common lead-pencil, the other of a pea. The knife in its passage had stripped off the serous membrane over a space of one inch by one quarter. There were two slits in the mesentery, each one inch in length, and the patient had lost much blood. The mural wound was closed by sutures which embraced only the skin and superficial fascia. None of the bleeding vessels had been secured, and active bleeding was still going on from three points in one of the wounds in the mesentery, the other being occupied by a clot. It was in this condition that the man was found by Dr. Roberts, shortly after his wounds had been dressed by another surgeon. Satisfied at a glance that the case had not been properly managed, Dr. Roberts reopened the mural wound, secured the bleeding vessel with carbolized catgut ligatures, stitched the opening in the gut more thoroughly, washed out the peritoneal cavity with hot carbolized water, and closed the abdominal wound with deep sutures, completing the dressing by inserting a drainage-tube in the lower angle of

the wound. Under this treatment, with proper subsequent care, the man made a rapid recovery. Had the dressing originally applied been allowed to remain, death would have been inevitable; either from hemorrhage, peritonitis, or peritonitis and septicæmia. The case affords a happy exemplification of hasty, careless, slovenly surgery, on the one hand, and of thoughtful, wide-awake, scientific surgery on the other.

The therapeutics after all such lesions is sufficiently simple. The great point is to prevent peritonitis, or to combat it, if it takes place. The posture should be such as to relax thoroughly the abdominal muscles. The bowels should be locked up with opium, to prevent peristaltic action, and nothing but iced water or pounded ice, aided, if there be much gastric distress, by a small allowance of dry champagne, should be permitted during the first three or four days. Oppression from gas should be relieved with injections of turpentine and asafoetida. Peritonitis should be met with leeching, followed by vesication with cantharidal collodion, and full doses of opium; venesection will be proper when the patient is young and robust. A laxative of castor oil, or of sulphate of magnesium, may be given at the end of five or six days, if there be marked suffering from tympanites. The urine should be drawn off during the first few days, with the catheter.

I have, thus far, said nothing of gunshot wounds of the intestines. Such wounds are generally of a very serious nature, and are, therefore, liable to be followed by the worst consequences. In the first place, they are nearly always concealed wounds, from the fact that there is no prolapse of the bowel; secondly, such wounds are commonly multiple, as in one of my own cases, in which there were as many as eight perforations—two in the ileum, two in the jejunum, two in the duodenum, and two in the arch of the colon; thirdly, there is always more or less copious effusion of fecal matter; fourthly, great shock, to say nothing of hemorrhage, which nearly always attends; and, lastly, most patients who survive the more immediate effects of such injuries are almost certain to succumb to peritonitis. The only rational treatment in such cases is to expose at once, or with the least possible delay, the peritoneal cavity, to stitch up, or excise, the wounded bowel, and, lastly, to clear away all extraneous matter. Excision of the tube is imperatively demanded when the wound is very large, severely contused, or very ragged. Nothing short of this would answer under such desperate circumstances; and even then no sensible surgeon would venture to pronounce a favourable prognosis.—*Med. News.*

PROF. PARVIN favors the employment of anæsthetics during the use of the forceps.

INFANT DIGESTION.

In the July number of the "Archives of Pædiatrics," Dr. H. R. Bigelow, of Washington, says: "The question of infant growth is one of assimilation. Assimilation of food will depend upon the integrity of the digestive function. The digestive system of the new-born is not formulated at once, but develops in logical ratio with the expansion of other parts of the body. Its measure is the requirement necessitated by the elaboration of tissue. Tissue-growth is a slow process, demanding special nourishment, and varied at each advance in age. The necessities of the child, both chemical and physiological, are not those of the adult, because each is adjusted with great exactness to the immediate environment. The excess of non-nitrogenous matter, which is an essential to adult life, is pernicious to the well-being of the infant. Muscles, when at work, consume principally hydrocarbonaceous aliments, and not albumenoid substances. In the infant there is no muscular exertion, and hence it draws more largely for its development upon the nitrogenous substances than upon the hydrocarbons. At birth the alimentary tract is short, the cæcum being very small and the masticatory organs are absent. Bidder says that the ptyalin appears only with the cutting of the first tooth. Reasoning from analogy, it is not improbable that the pancreatic and intestinal ferments are also inoperative until about the eighth month. Nature is not a spendthrift, and she would not call into useless action any function not demanded by the necessities of her own handicraft. With the eruption of the teeth a new era begins. Mastication presupposes increased development. Increase of development calls for increase of nourishment, and increase with variety in nourishment sets up new digestive processes, in which the ptyalin and other ferments play an important part.

"The alimentary tract of the infant is exceedingly susceptible, so the nursing women have to be very careful in their diet. Now, if this tract is so impressionable as to feel any departure from a standard diet in the mother, how much more seriously will it suffer in the administration directly of unwholesome cow's milk—not unwholesome, perhaps, in the light of general use, but unwholesome for the limited infantile digestion. It may have an *acid* reaction, or it may have come from a cow in *heat*, or it may be tainted with certain vegetable substances obnoxious to the child. The natural food of the baby is its mother's milk.

"An intelligent study of human milk will lead up to a more just comprehension of the demands of infant digestion, and to a more perfect knowledge of a physician's duty in prescribing for such cases as are, unfortunately, deprived of the mother's breast. It would be a valueless encumbering of space, and an expenditure of time without profit,

to cite one half the analyses that are matters of record. It best subserves the present purpose to view the main constituents of human milk in their relation to certain physiological principles. It is to be noticed first, that woman's milk has an *alkaline* reaction, which persists for an indefinite period, and a specific gravity of about 1.0317. It contains water largely in excess (89.20 in 100 parts) milk-sugar, nitrogenous matter, fat, and salines. The albumenoids will vary in different women so largely that we can not affirm that any analysis is infallible. A fair average percentage would probably be about 4.84. The milk-sugar (6.987) is much greater than in cow's milk (4.92). These figures are only approximately correct. No two samples yield the same results. This variability in the composition of women's milk, if not pathological, is a wise dispensation of nature to provide for the exigencies of each month of advancing age. Thus the function of the milk-sugar as a heat-producer is kept constantly in mind, while the absolute rate of nutrition may vary within wide limits, because the bodily heat must be preserved at all hazard. In fat, women's milk exceeds that of the cow, but falls far below it in albumenoids. The ash, or mineral constituent of milk, is chiefly concerned in metamorphosis. The basic phosphate of sodium is invariably found in the blood while the acid phosphate of potash is the chief constituent of the juice of the flesh. Phosphate of lime is intimately incorporated with the nitrogenous constituent principles. It is very generally admitted that the carbohydrates lead on to fat-production, through the co-operation of the nitrogenous and saline elements. Nitrogenous elements themselves, when in excess, may also serve as a source of fat. Nitrogenous matters do not, probably, undergo complete oxidation within the body; a portion of them is eliminated as urea. Fatty compounds are of higher value as force-producers, because they contain a quantity of hydrogen as well as of carbon free of oxidation. Pavy says that the value of nitrogenous compounds as force-producers depends upon the amount of unoxidized oxidizable elementary matter they contain. In human milk the percentage of nitrogenous matter to carbohydrates is about 1.45. About one fourth part of its casein is coagulable by acid. The *alkaline reaction* is *highly valuable*, since it serves to convert the *casein* into *soluble albumenoids* and soluble carbohydrates, which are great heat-producers. Writing upon this subject, Kuss says: 'It is generally admitted (Moleschott, Voit) that an adult consumes 320 grammes of carbon and 21 grammes of nitrogen, or in other words, 130 grammes of albumenoid elements, and 488 grammes of hydrocarbons and fats (fats 84, hydrocarbons 404); it follows that, in this case, the normal proportion in a mixed diet, of nitrogenous to non-nitrogenous aliments, is 1 to 3.7, while in milk, as well as in the egg, the proportion is 1

to 3, or even 1 to 2; in other words, the quantity of albumenates (nitrogen) is much larger, and of hydrocarbons (carbon) much smaller. This fact may be easily explained by referring to the part played by the hydrocarbons in regard to the production of force—muscular force especially. The adult draws his forces from the combustion of non-nitrogenous substances, the albumenates scarcely serving for this purpose. On the other hand, when the organism is in course of development, the nitrogenous substances are indispensable to the growth of the different tissues. It is therefore easy to see how mistaken is the common practice of condemning children to a diet containing a large quantity of starch and scarcely any nitrogen.'

'Women's milk contains no starch. It may be conceded that, in the adult, the ptyalin may continue its action in the stomach; that particles of unconverted starch may be transformed by the pancreatic and intestinal juices. In the infant this rule cannot apply. The baby does not secrete ptyalin until the sixth or eighth month, *neither do the other juices, of pancreas and intestine, have any transforming power whatever before that period.* It is sheer ignorance to assert small particles of starch can do no harm, since they undergo transformation in the intestine, when the truth is that they not only act as irritants, but pass out of the bowels unchanged. The attenuant of woman's milk is an important factor, of which we have little absolute knowledge. It is chiefly in consideration of this point that *cow's milk can not ever be safely substituted for that of the mother.* Before it can be satisfactorily approximated to this great food of nature it must be radically transformed by some chemical process, which science has not yet developed. The addition of water to cow's milk will reduce the percentage of albumenoids into harmonious relationship with human milk, but it does not suffice to change the characteristics of the clot. To use starch as an attenuant is, of course, radically wrong.

'In view of these facts, it becomes a matter of the utmost interest to establish some definite principles of treatment, in cases where the mother is unable for any reason to nourish her child properly and sufficiently. There is no known process, chemical or mechanical, by which cow's milk alone can subserve this purpose. Up to six months of age, at least, the baby needs just those equivalents found within the mother's breasts—nothing more and nothing less. The compound must be *alkaline* in reaction; it must contain no *cane sugar* (because cane-sugar must be first converted into grape-sugar before it can be assimilated; cane-sugar is frequently subjected to a kind of acetous fermentation, producing excess of acids in the infant stomach so that bodily heat will diminish and disorder of respiration and circulation will follow), and no *starch*. It must be rich in heat-producers, although as I have said before, the amount of albumenoid:

may vary greatly. Position has something to do with digestion. In some bad cases it will be found that, if the infant be placed in the usual position of a nursing child in its mother's arms, it will assimilate its food, when artificially fed, much more readily. In the nursing child a by no means inconsiderable amount of heat is derived from the mother's body. An artificially fed infant is deprived of this, so that there should be some compensatory action in its food. There have been many attempts made to overcome this difficulty, and our journals have been full of discussions upon the matter. It may be said that no artificially prepared food that does not meet in all these requirements will be of permanent value in infantile therapeutics. What is needed is something rich in carbohydrates, with a proper admixture of albuminoids, salts, and moisture, free from starch and alkaline in reaction."

Dr. Bigelow gives notes of three cases of disease in infants, with disturbed digestion or assimilation, in which great benefit attended the use of Mellin's food. "I satisfied myself," he says, "by personal analysis of the constituents of the preparation, and found that it contained the principles which it seemed to me nature demanded, in exact combination, and more satisfactorily and more cheaply prepared than I could compound upon my own prescription."

EPILEPSY TREATED WITH HYDROBROMATE OF CONIA.

BY R. NORRIS WOLFENDEN, B.A., M.B. CANTAB.

Being frequently disappointed in the action of potassium bromide in the treatment of epilepsy, I have lately been trying a remedy which I believe has not previously been used for this complaint. If the result is not quite so favorable as I might have expected, it is at any rate sufficiently good to warrant further trial, and I venture to place on record the notes of seven cases, in the hope that it may lead to further observations. We have all experienced the failure of potassium bromide until poured in in such quantity that often a condition of bromism is established. The unsightly blotches thus produced are a source of annoyance, especially to the better class of patients, to whom personal appearance is a matter of concern. The following is a summary of my notes.

CASE 1. A., girl, æt. eight: ill for two years, with epileptiform seizures consisting of sudden flexions of the fore-arm (right), and a momentary vacantness of look; latterly the attacks had become more severe, culminating in loss of consciousness. Hydrobromate of conia, in doses of half a grain three times a day, was prescribed. During the first week she had six slight "fits" The dose was

then increased to $\frac{5}{8}$ of a grain, and during the succeeding week she had no attack. The medicine was continued for four weeks, during which time she had no fits at all, and slept better. The drug was then discontinued for some weeks, when she returned for further treatment. During its administration this patient complained of constant frontal headache.

CASE 2. B., male, æt. 22: suffered from true epileptic fits, with typical aura, convulsions, unconsciousness, and great headache afterwards. One and a half grains hydrobromate of conia was ordered twice a day; during the week, this patient had nine fits. One and five-eighths grains was given twice daily for a week. During this time the patient had four bad fits. He was now, at his own request, put under potassium bromide, 3 j doses, three times a day, which kept them under.

CASE 3. C., female, æt. 34: had been ill for four years, with one or more fits every week, typically epileptic. While taking potassium bromide they were kept under. I ordered one grain of hydrobromate of conia twice a day to commence with. For a week she was better, with only one slight attack. The dose was increased to $1\frac{1}{4}$ grains, and during the next fortnight she had one slight fit. She was then ordered back to bromide.

CASE 4. D., girl, æt. 7: has seven or eight fits a week, of a typical epileptic character. She has frequently right-sided convulsions, the right arm being suddenly flexed. Sometimes these culminate in a real fit, with insensibility and rigidity. The child is an imbecile. As while under 3 j doses of bromide, the child still had frequent fits, I ordered $\frac{1}{4}$ grain of hydrobromate of conia three times a day. For the first week she had five fits (all occurring the day after the medicine was changed). For the second week there were seven fits. The drug was increased to $\frac{1}{2}$ grain three times daily. For a fortnight she was absolutely free from fits, and then had seven. The drug was continued for some weeks, but she still had fits occurring at irregular intervals, which were refractory both to conia and potassium bromide.

CASE 5. E., female, æt. 27: has typical epileptic fits which continue under 3 j doses of potassium bromide. I administered $\frac{1}{2}$ grain of hydrobromate of conia three times a day. During the next week she had no fits and stated that she felt better, but with frequent headache. For a month while under this treatment she had no fit, but complained of more frequent headache, in consequence of which I returned to bromide.

CASE 6. F., male æt. 18: would have three fits a day, and then go for a week without. They were typically epileptic fits. While under large doses of bromide they were kept under, but not until an unsightly bromide rash was established, which was troublesome to the patient. For the first week, while taking one grain hydrobromate of conia twice daily,

he had three fits. For a fortnight longer while under this treatment he had two fits. During the whole three weeks he therefore had five typical epileptic fits. As he stated that the drug made him feel giddy and weak, I returned at his own request to bromide, which so long as he was entirely under its influence in large doses seemed to ward off his attack. This young man was of weak intellect.

CASE 7. G., female, æt. 15 : suffered from true epilepsy, dilated pupils; her optic discs were congested. She had not menstruated and had phthisical symptoms (cough, hæmoptysis, sweating). Half-grain doses of hydrobromate of conia were ordered three times a day. During three weeks she had no fit, which she stated was the longest time she had ever been without. I then lost sight of her.

The conclusions I draw from the treatment of these seven cases are—that the drug is undoubtedly serviceable in certain cases, and those in which it fails are cases of convulsions depending possibly on some gross lesion of the brain (Cases 4 and 6). The slighter cases (*e. g.* Cases 1 and 7) were distinctly benefitted by it.

The drawbacks to the use of the drug appear in the complaints of headache, and where in large doses, of giddiness lasting for an hour after taking it, with sometimes a suffusion and congestion of the conjunctivæ. In the doses in which I have given it, there has not been noticed any cardiac or respiratory alteration. It is said that the dose of this drug must not exceed $4\frac{1}{2}$ grains in 24 hours, commencing with $1\frac{1}{2}$ grains. In my experience a child of eight bore $1\frac{7}{8}$ grains with only headache; a child of 7 took $1\frac{1}{2}$ grains per diem, without any complaint: $2\frac{1}{2}$ grains per diem, were taken by a female without complaint: one adult man took $3\frac{1}{4}$ grains with impunity. In one case two grains per diem caused sickness, headache, giddiness, and "weakness" in a man of 18. One and a half to two grains appears to be followed frequently by headache. I think the drug deserves further trial. Combined with constant application of the continuous current, I have successfully treated with it a case of hemichorea. In this disease however, it would be rash to speculate whether the drug, the galvanism, or the time was the most effectual in the cure.—*Practitioner*, June.

THE TREATMENT OF DIABETES MELLITUS.

In the *Col. and Clin. Record* Aug. 84. Dr. Flint Jr. gives the following summary of treatment. He says:—"The more I study the cases of diabetes that have come under my observation, especially those that are now under treatment, in connection with the writings of those who have faithfully followed the dietetic plan, notably Bouchardat and

Cantani, the more thoroughly I am convinced that the prognosis in a recent and uncomplicated case of this disease in an adult is invariably favorable, provided, always, that the proper measures of treatment be rigidly enforced. In the hope of convincing the profession that this statement is reliable, I shall at the risk of what may appear to be needless repetition, give a summary of treatment, with brief statements of the progress of cases that I am now actually observing.

At the outset, patients should be impressed with the fact that they are suffering from a grave disorder, and that everything depends upon their full co-operation in the treatment, which treatment is essentially dietetic. The diet table should be carefully studied, and the diet regulated and carried out absolutely. In case a rigid anti-diabetic diet does not promptly influence the glycosuria, it may be well to subject the patient to an absolute fast for twenty-four hours and follow this with anti-diabetic regimen. This rather harsh measure is suggested by Cantani. I shall not hesitate to employ it in cases in which it may seem to be required, although no such case has yet come under my observation. Systematic daily muscular exercise should be enforced. A moderate system of training on the plan adopted by athletes is most useful; and this, if continued, will do much to render a cure permanent after a return to the normal diet.

The return to a normal diet should be gradual, and during this time the urine should be frequently examined, the rigid diet being resumed at the first reappearance of sugar in the urine; but all alcoholic excesses, the immoderate use of sweet fruits, and any use of sugar, should be interdicted at all times. A patient who has once had diabetes is always liable to a return of the disorder. He must lead a thoroughly careful, hygienic, and temperate life. In the words of Bouchardat, "you will not be cured except on the condition that you never believe yourself to be cured."

While I believe that the physician is justified in encouraging patients to expect relief, and even cure, in recent, uncomplicated cases, the diet is all important, and its regulation cannot be expected to be perfect without professional aid in its enforcement. A diabetic is never safe from a return of his disease, even when he believes himself to be cured; and under no circumstances should he pass more than a few weeks without an examination of the urine.

The arsenite of bromide, or Clemen's solution, appears to be useful. It consists of arsenious acid and bromine dissolved in water and glycerine in such manner that two drops represent the 24th part of a grain of arsenite of bromine. We may begin with 3 drops three times daily in a little water immediately after eating, gradually increasing the dose to 5 drops. This may be continued for weeks and months without producing any unfavor-

able effects; but the administration of this remedy does not supply the place of the dietetic treatment, which should be enforced in all cases. Cantani recommends lactic acid "lemonade" 1 to 2 drachms to the pint of water and flavored. A rigid diet should be continued for two months, at least, even in the mildest cases of the disease. It may be necessary, in certain cases, to continue it for a longer period, even twelve or more months. There is probably no such disease as intermittent diabetes. In some instances glycosuria occurs during the season of sweet fruits, when they are indulged in excessively, and disappears when the diet is changed; but these are mild cases of diabetes, excluding those in which a transient glycosuria follows the inhalation of irritating vapors, the taking of anæsthetics, etc. Robust or corpulent persons are more tolerant of the disease than those who are feeble or spare, and the glycosuria yields, in such cases, more readily to treatment.

Diabetes occurs at all ages. Bouchardat mentions a case in an infant of 3 years, although the disease is rare before the age of 12. The most unfavorable cases are those which occur before the age of puberty. An adult male presents the most favorable conditions for cure. In old persons, when the disease is of long standing, the dietetic treatment will secure practical immunity from nearly all the distressing symptoms, although the glycosuria may not be entirely removed. A study of any of the diet-papers recommended will make it evident that those who are able to follow the required regimen, without regard to the cost of articles of food, present much more favorable conditions, as regards the prospect of cure, than persons in straightened or indigent circumstances. Diabetes, however, occurs in all classes, and is by no means a rare disease. A hospital devoted to such cases, where the dietetic treatment could be strictly carried out, would be a boon to the rich and poor alike."

ANEURISM CURED BY DIGITAL COMPRESSION IN SIX HOURS AND A QUARTER.

In the *Brit. Med. Journal*, Arthur E. J. Baker, F.R.C.S., Eng., of University College, reports the following interesting case:

J. D., aged 36, was admitted into University College Hospital, under my care, on August 29th, 1883, suffering from an aneurism of the right popliteal artery. For this he had been already carefully treated, by M. Gandy, of Norwood, with a Skey's tourniquet, applied almost continuously for five weeks. This compression had had no effect upon the tumour. The patient was a particularly healthy, fresh-looking, cheerful man, whose personal and family-history were excellent, and

showed no evidence of constitutional disease of any kind. He had always been a gardener, working for the last eleven years in a very hilly garden, and doing all the work (which was very heavy) himself. This overstrain appears to have been the only exciting cause for the aneurism in this case. The appearance of the tumour dated from eight weeks before admission, when he first noticed pulsation in the ham. He was unaware of any special strain or other cause for it, and it gave him at the time no pain. Its size had remained the same since first observed. On admission, the swelling was of flattened oval shape, about two inches in diameter; it was tense and elastic, and pulsated strongly. It was seated exactly opposite the middle of the knee-joint, and was slightly red on the surface, having a distended vein on its outer side. There was aching pain on flexing the leg, but none when the limb was at rest in extension; some tenderness on pressure on the tumour was complained of, but none in the thigh or leg. Pressure on the superficial femoral artery arrested all pulsation in the sac.

Instrumental compression having failed, and the man being extremely anxious that something radical should be done, I ligatured the superficial femoral artery in Scarpa's triangle on September 6th, 1883. The operation was done in the usual way under spray, and the vessel was tied with a twisted silk ligature well carbolised, which was cut short and left in the wound. The first ligature broke in drawing the second half of the knot; the next piece of silk bore the strain well, and was placed a quarter of an inch above the first spot chosen. The pulsation in the aneurism was now found to be completely controlled, and no pulsation was felt in it until about five hours later, when it was just perceptible. The tumour gradually shrank, while over it a small artery could be easily felt. The wound healed, without any trouble of any kind, by first intention throughout, the ligature showing no signs of coming away. The patient left hospital on October 1st, looking and feeling very well. At this time there was no pulsation to be felt in the tibial arteries, and no discomfort or pain anywhere. In this condition the patient remained at home until the second week in January, 1884, (about four months). He then noticed a return of pulsation in the right popliteal space, with pain in the knee as this gradually increased. A week later he came up to see me, when I found the aneurism almost, if not quite, as large as before the ligature of the femoral artery, although the latter, below the seat of ligation, was now pulseless, as were also the tibials. Above the ligature the vessel pulsated strongly. Pressure on the common femoral, below Poupart's ligament, completely controlled the expansile stroke in the aneurism, and from this there could be no doubt that it was fed by branches of the profunda, which had been

presumably enlarged during the five weeks of instrumental compression of the common femoral, which had preceded ligature. Of course here there could be no question of the ligature having dissolved away, as it was of strong silk, and the vessel was still pulseless below its seat; moreover, pressure on the femoral at this spot did not affect the aneurism, whereas pressure above the profunda did so at once.

I now determined to try digital compression, and, on the readmission of the patient on January 26th, he was put upon a somewhat restricted diet for two days, being confined to bed, and smartly purged. The effect of this treatment in lowering the arterial tension was most marked, and to it, no doubt, some of the good result may be attributed. Then, on the 28th, having a number of most willing volunteers from among the students, I commenced digital pressure of the common femoral at 10:50 A.M. This was carried out with the same attention to details referred to in my former case, and, at 5.15 P.M., all pulsation in the aneurism had ceased finally. Compression was still continued until 8 P.M., and then stopped. The temperature of the limb remained lower than the other for some time, but all discomfort and pain was soon gone. The patient returned home cured on February 5th. Since then, I have seen him several times; there has been no return of the aneurism, which has shrunk up to small size. The pulsation in the tibials is still absent. The man is now engaged in his gardening work as before, without any pain or trouble from his former ailment.

EARLY SYMPTOMS OF CANCER— HUTCHINSON.

As Emeritus Professor, Professor of Clinical Surgery Mr. Hutchinson is now delivering his second annual course of lectures at the London Hospital. This course was instituted last year on the occasion of Mr. Hutchinson's retirement from the acting surgical staff, when he was appointed consulting surgeon. It was considered desirable to retain him as a teacher in connection with the Medical College, so he was made Emeritus Professor, and undertook to deliver six lectures annually on some subject connected with surgery.

The lectures for the present year are perhaps a greater success than those given last summer, and being wholly delivered extempore appeal more directly to the minds of the auditors. It goes without saying that Mr. Hutchinson gives no mere summary of ordinary text-book opinions, but lays before his hearers, in plain and unmistakable terms, the results of his own clinical experience.

On Wednesday, July 2nd, a good audience assembled to hear the lecture on "The Early Recognition of Cancer." The term "cancer" was used

in its clinical sense and as including sarcoma, and not in its limited anatomical sense applying solely to carcinomatous growths. The importance of its early recognition was obvious. Mr. Hutchinson said that before the actual presence of cancer was what might be termed the pre cancerous stage, and this was essentially a condition manifested by signs of local inflammation. An interesting case was narrated in support of this view. It was that of an old gentleman whom Mr. Hutchinson saw in consultation some years ago. One testicle had enlarged and was slowly increasing in size. The surgeons who saw the case agreed that it was probably not malignant and recommended non-interference. It continued to grow, however, and was at last removed solely by request of the patient, who had all along been anxious about it lest it should be cancerous. It was examined microscopically and was found to be simply in a condition of inflammatory hyperplasia, and no signs whatever of malignancy were discoverable. The patient recovered from the operation, no further trouble manifested itself, and his medical attendants came to the conclusion that his testicle had been unnecessarily removed. Two years elapsed. The remaining testicle then began to enlarge in the same way in which the other had done. Remembering the result of the previous operation, the surgeons strongly advised the patient against operation. As before, it continued to enlarge until finally it reached a considerable size. At last even the surgeon began to be alarmed and the patient's anxiety was extreme. The testicle was at last removed at the urgent request of the patient. It was examined and proved to contain a well marked sarcomatous growth. The inference was that the one first removed would, if allowed to remain, have also acquired a sarcomatous structure, and that the inflammatory hyperplasia found was a condition leading up to that of actual malignancy.

Eczema of the nipple preceding cancer was an illustration. Mr. Hutchinson remarked that cancer attacked parts that were functionally dead, as the breast in women late in life. Among animals it attacked the cat, the dog, and the horse, but not the sheep. The two former animals led a lazy life and were allowed to drag out their existence to old age. Sheep were usually killed before they were old enough to develop cancer.

The practical conclusion Mr. Hutchinson drew from his view was to treat as cancer all those cases where you suspected it—to adopt active measures at once and not wait for more decided symptoms until it might be too late.—*Med. Record.*

Oliver Wendell Holmes says that the great secret of success in every form of quackery is hope kept alive in the patient; while the too fatal gift of science is a prognosis of despair.

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The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

MEDICAL SCHOOL OPENINGS.

The first of October is generally considered a red-letter day among medical students and professors in medical colleges in Canada and Europe. In many medical colleges both at home and abroad, it is customary to begin the work of the session with an introductory lecture on some general or special topic. In some the practice has been discontinued, and in others revived after a period of suspense. The beginning of the present session has been no exception to the general rule. Our exchanges bring us brief reports of the medical school openings in the mother-land, and the festivities which accompanied them in the form of hospital dinners and conversaciones. Some of these were on a grand scale of magnificence, and were the means of bringing together in friendly intercourse, old class-mates, fellow students, and professors. St. Bartholomew's, Guy's, St. Thomas', St. Mary's, King's, London, etc., vied with each other in the character and success of their respective festivities, and the friends and patrons of each turned out in force to do honor to the occasion. Although in Canada we have not yet inaugurated the festive part of the programme, we have not lagged behind in the "feast of reason." The introductory lecture is now a constant feature in all the medical schools in Canada, and in its general scope and character will compare favorably with those of a similar character in older and more favored countries.

The introductory lecture of the course in Trinity Medical College, Toronto, was delivered by Prof. Geikie, Dean of the Faculty. After welcoming the assembled class, he referred to the large graduating class of last year and the honor they had done the school and themselves by their successful examinations at home and abroad. Their example was held up as a model, and a like success was confidently predicted for all who would bring diligence and perseverance to bear upon their studies. The lecturer chose as his main subject, the history of the origin of medicine amongst the Egyptians, Jews, Greeks, and Romans, passing down through the centuries to our own times. He dwelt upon many medical superstitions, especially those connected with amulets and charms. He closed with a strong appeal to those present to prosecute their studies with that zeal and thoroughness which alone would lead to distinction during their college career, and throughout their entire subsequent professional life. He also earnestly cautioned them against giving way to any temptations to idleness or vice. They were urged to be very careful in the choice of their companions, and especially to steer clear of any who have the misfortune to rank amongst either the idle or the vicious.

At the Toronto School of Medicine the opening lecture was delivered by Dr. George Wright, who, after welcoming the students and referring to the success of the school, gave some timely advice to those about to enter the profession. He alluded to the interesting character of the study of medicine to the enquiring mind. The whole domain of nature, animate and inanimate, came under their observation in some way or other. They were now laying the foundation in professional work which was either to make or mar their success through life. He was a firm believer in the doctrine that each one had special adaptabilities, and the more accurately these could be gauged the more likely would be the success. He cautioned them against the tendency to be content with purely theoretical knowledge, and advised them to utilize all the advantages within their reach for the practical study of disease in all its varied phases. He deprecated any slipshod preparation in so important a profession and condemned the three years' course system. Brief addresses were also delivered by Drs. Workman, Thorburn and Richardson.

The opening lecture of the Royal College of

Physicians and Surgeons, Kingston, was delivered by Dr. Fife Fowler, Dean of the Faculty. He referred to the many successful students who had been educated in the College and who now occupy positions of honor and usefulness. Genius, accompanied by energy and application, could accomplish wonderful results; but the careful, plodding, persevering student often in the end succeeded in obtaining what the restless, fitful men of talent failed in accomplishing. He then referred to the motives which impel men in the race of life: that while some are urged on by envy, the love of success, or the love of money, the highest motive was the knowing and the doing of one's duty. Life should be viewed with exalted and purified minds, and the moral nature should be matured and elevated. The necessity of bed-side observation was strongly emphasized. The importance of being honest in thought, word, and deed, and the usefulness of acquiring business habits was referred to. He also dwelt on the importance of having such moral qualities as decision, courage, self-reliance, and individuality, and although their paths would not all be paved with daisies, he advised them to be of good cheer and arm themselves with prudence, fortitude and truth.

At the opening of the medical department of the Western University, London, Dr. J. M. Fraser delivered the introductory lecture. He referred to the good conduct and success of the students of the classes in previous years, and to the gratifying results of their efforts in the local examinations as well as at those of the Ontario Medical Council. He next referred to the responsibilities the medical student assumed on entering the profession, whose aims were to alleviate human suffering and prolong life. The responsibilities at the bedside of the sick and the suffering were of the gravest description, and required the highest cultivation and preparation, nicety of perception, calmness of judgment and an utter avoidance of self-seeking propensities or arrogance. He pointed out many of the solemn and sacred duties which the physician owes to his patient, or to the families of those with whom he comes in professional relation, and showed how necessary on his part was the exercise of kindness and sympathy. He pointed out the high aims before the student of medicine, noted the difficulties and obstacles to be overcome, indicated the vastness of the fields of medical science as yet unex-

plored or only partially understood, and expressed the hope that among those who, in the future, will be eminent in the profession and benefactors of the race, might be graduates of the Western University.

The opening lecture of McGill Medical College, Montreal, was delivered by Dr. Penhallow, Prof. of Botany in the University. The subject treated upon was "the relative position which the teaching of botany holds in the various schools in this country and the United States." The lecturer dealt with the question in an able and comprehensive manner, and was listened to with marked attention. Space does not permit our giving a digest. The prospects of the school for the present session are good, upwards of seventy new students having registered up to the 15th ult.

Up to the time of writing we have had no official reports from Bishop's Medical College, Montreal, or the Winnipeg Medical College, but have learned indirectly that their prospects for the present session are very good, the attendance being greater than last year.

The opening of the Women's Medical College here and in Kingston also took place on the 1st ult. The following extract from the address delivered by Dr. Alice McGillivray, at Kingston, may be taken as representing the sentiments of those who favor women entering the arena of medicine: Ladies, whatever your motive in undertaking this serious responsibility, whether it be from a desire to earn a livelihood or to provide against future contingencies, or from a realization of the many existent ills among those of our own sex, who shrink from seeking relief elsewhere, or in response to the appeal from the multitude of our suffering sisters in India, who are permitted to die unattended, we know each one of you will strive to achieve a high place as a student, to preserve all good grace becoming a lady, and in future to distinguish yourselves as much by your womanly dignity of character and goodness of heart as by your skill in the profession.

The number of those entering the profession seems to be ever on the increase. This year especially there would appear to be a much greater number than in previous years. McGill College, as before stated, has upwards of 70 freshmen. In the Kingston School the freshman class is larger than usual. The Toronto School of Medicine has

a goodly number. The number of freshmen in Trinity Medical School this session mounts above 100, the entire class numbering about 250. Abernethy's exclamation may well be reiterated: God bless you, gentlemen! What is to become of you all!

THE QUEBEC LUNATIC ASYLUMS.

Grave complaints have been made from time to time for several years past by well-informed persons regarding the management or rather mismanagement of the asylums in the sister Province of Quebec. Dr. Hack Tuke, the well known alienist, who accompanied the British Association to Canada, availed himself of the opportunity to visit the asylums in Ontario and Quebec. The report of his visits to the Quebec Asylums was forwarded to the Hon. the Provincial Secretary, and has been made public. It is in truth a formidable indictment of the general management and moral treatment of the unfortunate insane in that Province. In regard to the cleanliness and order in the principal parts of the asylums there is much to commend; but in the upper stories and the refractory wards he finds "a skeleton in every closet." The wards are poorly lighted and ventilated, and almost destitute of any provision for the comfort of the inmates. One ward in the Longue Point Asylum, Montreal, he characterizes as a "chamber of horrors." In the corresponding portion of the building on the female side matters were no better—"a veritable pandemonium." Many were restrained by various mechanical appliances—muffs, manacles and straps—who should have been governed by moral restraint alone. They were closely huddled together and the atmosphere was stifling in the extreme. In the fourth story were the idiots and imbeciles, removed from all humanizing influence, treatment or education. The condition of the patients confined in the gallery, roof and basement, was beyond adequate description. In contrasting the condition of the asylums in Quebec with those in Ontario he says:—"The astonishment which I experienced in witnessing this relic of barbarism in the Province of Quebec is still further increased when I see such excellent institutions as the lunatic asylums of the adjoining Province of Ontario. I am certain that if it were possible to transfer the worst patients now in the asylum at Montreal to

these institutions, they would be freed from their galling fetters and restraint chains. They would quit their cells also, and, in very many instances, be usefully occupied where they are now restrained, with the result that in not a few cases perfect recovery to health would follow. 'Look on this picture and on that,' were words constantly in my mind after visiting the institutions of the two Provinces."

In discussing the cause of this lamentable state of affairs, he says, it is due entirely to the contract or farming system. This, it cannot be too often repeated, is the essential root of the evil, and unless speedily abolished will bear bitter fruit. In the conclusion of his report Dr. Tuke advises the Government to undertake the responsibility of providing the necessary accommodation and treatment of the insane poor, appoint resident medical superintendents with full authority, a competent board of management and efficient inspectors, and then the asylums would become institutions of which they would be proud instead of institutions of which they are now heartily ashamed.

ANOTHER MALPRACTICE SUIT.

At the recent assizes in this city an action was brought by a patient named McClure against Dr. Grant, of Woodbridge. The plaintiff had the misfortune to receive a severe fracture of the leg from a kick in a drunken brawl. Dr. Grant was called in and treated the fracture by means of a fracture box, first applying a bandage to the limb. About the ninth day dry gangrene began to appear in the great toe. Dr. Stevenson, of Kleinburg, was called in consultation, and both he and Dr. Grant examined the bandage and came to the conclusion that whatever might be the cause of the gangrene, it was not due to the bandage. On the following day, Dr. Savage, of Thistleton, visited the patient in the absence of Dr. Grant, removed the bandage, and gave the plaintiff to understand that it was the cause of the gangrene. The gangrene then spread to the remaining toes and dorsum of the foot. After the line of demarcation formed, the anterior part of the foot was amputated by Dr. Savage, who had taken charge of the case, assisted by Dr. Heggie, of Brampton. In a few months afterwards the ankle-joint began to suppurate, and a second am-

putation was performed above the joint. The fractured bones and amputated foot were produced in court. There was fracture of the lower end of both bones, the fracture of the tibia being comminuted and extending into the joint, and the astragalus was fractured horizontally. The principal evidence for the plaintiff besides himself, was Dr. Savage, who was positive that the whole difficulty arose from the tightness of the bandage applied to the limb. Dr. Heggie at first thought the gangrene was due to the bandage, but said it might be due to other causes. Dr. Bull's evidence favored the defendant. For the defence, the evidence of Dr. Grant, and Dr. Stevenson went to show that every care had been exercised and that the bandage was not too tight at any time. Expert testimony, consisting of the evidence of Dr. Sullivan, of Kingston, Drs. H. H. Wright, Fulton, Bethune and others, of Toronto, was also brought forward, which went to prove that the accident itself was of sufficient severity to produce the gangrene, by injuring the anterior tibial artery, and that it could not have been caused by the bandage, inasmuch as the sole of the foot was not affected, and the gangrene was of the dry, instead of the moist variety. The judge, who was unable to comprehend the bearing of the expert evidence in the case, charged against the defendant, and the jury brought in a verdict for the plaintiff with \$750 damages. The case will be appealed. Comment on the unmanly and unprofessional conduct of Dr. Savage in this case is wholly unnecessary.

QUEBEC MEDICAL BOARD.

The semi-annual meeting of the Quebec Medical Board was held in Quebec on the 24th of Sept. under the presidency of Dr. C. E. Lemieux. There was a full attendance of members present. After the reading of the minutes a resolution of condolence was passed on motion of Drs. Guay and Bel-leau, respecting the death of Dr. J. E. Landry, a member of the Board. The report of the examiners for the preliminary examination was read and adopted. Of 34 candidates 19 were admitted. The Treasurer, Dr. E. P. Lachapelle then read his report, which showed that \$5,322 had been raised during the past year, and after paying all expenses there was a balance of \$1,579 on hand. It also stat-

ed that the balance on hand was being continually diminished and suggested that means should be taken either to increase the income or lessen the expenditure, and a committee was appointed to enquire into the matter. The report of the detective showed that several actions had been instituted against illegal practitioners which were still pending in the courts. Dr. R. P. Howard, presented the report of the committee to enquire into the charges brought against the professors of Victoria College by Dr. Lachapelle, of having furnished copies of the questions to their students prior to the professional examination last spring. The consideration of the report was postponed until the next meeting. Notice of motion was given that at the next session of the Provincial Parliament a petition be presented praying for an amendment to clause 3, chap. iv. of the statutes and by-laws of the College of Physicians and Surgeons of Quebec, and that the words, "without examination" be replaced by the following, viz.: "after examination," the said examination to be upon the following subjects: medicine, surgical anatomy, descriptive anatomy, surgery, obstetrics, and materia medica.

The following gentlemen received the license of the college—Drs. P. Coote, M. R. G. Matte, E. Pelletier, E. Larue, E. Gosselin, J. A. Milette, A. Morin, F. S. Caron, E. Duval, C. N. Valin, M. T. Brennan, O. Berthiaume, F. H. Daigneault, W. Fournier, H. Leduc, J. O. A. Beaupré, H. Gauthier, R. Migneault, A. Richard, H. Brosseau, J. O. Stewart, A. Stewart, C. E. Cameron, J. A. Hutchison, and B. F. W. Hurdman.

ACTION FOR SLANDER.—This was an action brought by Dr. Hunter, at the recent assizes in this city, against Dr. Freel, both of whom reside in the village of Stouffville, Ont. Dr. Hunter attended a woman in her confinement. The labor was natural and the placenta came away without any trouble. On the fourth day afterwards she had a chill which was followed by an attack of pelvic cellulitis from which she died. Dr. Hunter complained that Dr. Freel, who had been called in the day before the woman died, stated to the friends of deceased that he (Dr. Hunter) had left a portion of the placenta in the uterus, which was the cause of the woman's death. This statement was also made to several parties in the village, and hence

the action. For the defence Dr. Freel called witnesses to prove that Dr. Hunter himself stated that he was afraid a portion of the placenta had been left in the uterus, and that the friends of the deceased mentioned this to Dr. Freel. His reply was "if Dr. Hunter left a portion of the placenta in the uterus it would account for the woman's condition," and this was essentially the statement he had made to other parties in the village. Dr. Hunter and his witnesses on the other hand testified that the statement was to the effect that if he (Dr. H.) had been obliged to remove the placenta a portion might have been left and caused trouble, but under the circumstances he could not account for her condition. A large number of witnesses, lay and medical were examined on both sides, and the trial occupied three days. In his charge to the jury the judge explained that any expression of opinion by Dr. Freel to the friends was privileged, but statements made to parties outside adverse to Dr. Hunter, or with a view to injure him constituted slander. The jury found a verdict for the plaintiff and \$50 damages.

APPOINTMENTS.—Dr. T. W. Mills has been appointed Prof. of Physiology and General Pathology in McGill Medical College, *vice* Prof. Osler; Dr. Wilkins, Professor of Practical Histology, and Dr. Sutherland Professor of Morbid Anatomy.

Drs. P. R. Inches, St. John, N.B. and J. H. McCollum, Toronto, have been appointed medical examiners under the Civil Service Act.

CORONER.—Dr. D. D. W. Harrington, of Halifax, has been appointed coroner for the City and County of Halifax.

ACKNOWLEDGMENTS.—The Chairman of the Ontario Board of Health desires to acknowledge with thanks contributions to their reference library of hygiene from the following publishers:—D. Appleton & Co., New York; A. E. Wilde & Co., Cincinnati; Henry C. Lea's Son & Co., Philadelphia; Jansen, McClurg & Co., Chicago; G. P. Putnam's Sons, New York; Houghton, Mifflin & Co., Boston; Harper & Bros., New York; Geo. S. Davis, Detroit.

AMERICAN PUBLIC HEALTH ASSOCIATION.—The 12th annual session of this association was held in St. Louis, Mo., on the 11th of October and three

following days, under the presidency of Dr. A. C. Ghion. About 150 members were present. A large number of interesting papers on sanitary questions were read and discussed. Dr. C. W. Covernton, President of the Ontario Board of Health, and Dr. Bryce, Secretary, were present as delegates from Canada.

MEDICAL COUNCIL ELECTIONS.—Dr. Allison, of Bowmanville, will again be a candidate for election to the Council for the Territorial Division of King's and Queen's. He has been a most able and faithful representative and we hope to see him re-elected. We know that the interests of the profession and the Council are very dear to him, and are in hopes that he will, some of these days, grant the institution a liberal endowment.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.—The following have been elected officers of this Society:—President, Dr. Roddick; 1st Vice do., Dr. Alloway; 2nd Vice do., Dr. Trenholme; Treasurer, Dr. Molson; Secretary, Dr. Gurd; Librarian, Dr. Reed; Council, Drs. G. Ross, Kennedy and Rodger; Publication, Drs. Cameron, Ross, Bell and Kennedy.

REMOVALS.—Dr. Coleman, of St. John, N.B., has removed to Baltimore, U.S., to practice his profession. He carries with him the hearty good wishes of his Canadian confreres.—Dr. Atherton, of Fredericton, N.B., has removed to this city. We welcome him to our midst and wish him every measure of success and prosperity.

TRIPLE VALERIANATE.—Dr. Goodell recommends the following in the treatment of certain nervous diseases in females:

R Quinæ Valerian.
Ferri "
Zinci " aa grs. xx.—M.
Ft. pil. No. xx.

Sig. One three times a day.

PRESENTATION.—Dr. Aiken, of Weston, Ont., who is removing to California, on the occasion of his departure, was presented with an illuminated address, accompanied with a silver tea service for Mrs. Aiken, by his numerous friends in the village and neighbourhood.

THE NEW LOCAL ANÆSTHETIC.—The new local anæsthetic, cocaine hydrochlorate, recently discovered in Germany, is giving most astonishing and satisfactory results in the hands of specialists, as reported in the *N. Y. Medical Record*. Drs. Noyes, Agnew, Moore and Minor all speak in enthusiastic terms of its value. A few drops of a two per cent. solution is dropped in the eye three or four times at intervals during a period of fifteen minutes. The effect is to produce such profound local anæsthesia as to permit of operations, such as division of the recti muscles, being done without the patient complaining or showing any signs of pain. The new remedy is the reigning sensation in New York among specialists.

STAMP CANCELLATION.—We learn from the *Daily Star* that Dr. Griffin, of Montreal, has invented an instrument for cancelling postage stamps. It is stated that the loss to the governments of Canada and the United States through inefficient stamp cancellation, ranges from \$10,000 to \$50,000 respectively. The instrument will be tested in the Montreal post office, and if found satisfactory will be adopted generally. The instrument cuts a piece out of the stamp, but does not go through the envelope.

THE BRITISH CHOLERA COMMISSION.—The Commission, of which Dr. Klein is the principal, are busily prosecuting the work in Bombay, and have made experiments with the microbes which led them to doubt the infectious nature of Koch's cholera microbe. Dr. Klein has shown his contempt for the microbe theory by swallowing a number of so-called cholera bacilli without any ill-effects.

COMPLIMENTARY DINNER.—The medical profession of Montreal gave a complimentary dinner to Dr. Osler prior to his departure for Philadelphia. The chair was taken by Dr. R. P. Howard, and about fifty members were present, all of whom united in wishing their guest abundant success and prosperity in his new sphere of labor.

MUNIFICENT DONATION.—A donation of half a million dollars has been given to the College of Physicians and Surgeons, New York, by Wm. H. Vanderbilt. This is an example of generous and public-spirited liberality which is worthy of the highest commendation. It is to be hoped that it is only the beginning of good things in store.

Books and Pamphlets.

THE LAND OF BURNS, and other Pen and Ink Portraits. By J. Campbell, M.D., Seaforth, Ont.

This interesting work by Dr. Campbell will be issued from the press in a few weeks, and the profession will, we are sure, be pleased to patronize it. The subject is an inviting one, and the author is quite competent to make it entertaining. We bespeak for the author and the work the kind consideration and patronage of the profession in Canada.

HOOVER'S PHYSICIAN'S VADE MECUM; with an Outline of General Pathology, Therapeutics and Hygiene. 10th edition. Revised by William Augustus Guy, M.B., Cantab, and John Harley M.D., London, F.L.S. New York: Wm. Wood & Co.

The original work of Dr. Hooper, published as far back as 1823, has been such a great favourite with the profession, that every few years the proprietors of the original copyright have placed it in the hands of successive editors, by whom it has been brought down to the present level of the various subjects treated on. The work, as now presented to the profession, may be recommended as a useful reference to all items of information in clinical medicine, to both student and practitioner. Both volumes are largely illustrated by wood engravings, and an extensive collection of formulæ, preceded by classified lists of the British Pharmacopœia, with their doses, is added.

MATERIA MEDICA AND THERAPEUTICS. By Mitchell Bruce, M.A., M.D., London. Philadelphia: H. C. Lea's Son & Co.

This hand book is one of the very best of an excellent series. It is new, condensed and eminently practical in its character. It is divided into three parts: I. The inorganic. II. The organic materia medica. III. General therapeutics. This book, small in size, but large in the amount of information it contains, is sure to have a large sale.

Births, Marriages and Deaths.

On the 15th ult., J. E. Brouse, M.D., of Brockville, Ont., to Amelia Mary, only daughter of P. L. Allen, Esq., of Hamilton, Ont.

On the 28th ult., the beloved wife of Dr. J. Fulton, editor of the CANADA LANCET, Toronto, aged 40 years.

On the 1st ult., Dr. J. A. Aikman, of Ingersoll, Ont.

On the 21st ult., Dr. J. S. Diamond, of Toronto, aged 45 years.

THE CANADA LANCET.

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Original Communications.

NOTES ON FIVE CASES OF OVARIOTOMY.

BY A. B. ATHERTON, M.D., L.R.C.P. & S., ED., TORONTO,
(Formerly of Fredericton, N.B.)

CASE I, March 12, 1876.—Mrs. H., æt. 49, never menstruated but once in her life, when 17 years of age. Had distinct menstrual molimen every month, however, till four or five years ago. Married at 22 years. Husband died seven years ago. Three years ago noticed first a tumor in left inguinal region. Was examined by me about a year afterwards, when it was of size of adult head, and I diagnosed ovarian tumor and advised her to have it removed when it got somewhat larger. Nearly a year after I saw her it had become so large that another medical man who was consulted tapped her. Since then he has repeated the operation some six or seven times. As the tappings have of late been required at shorter intervals than at first, and as her health has been failing, she called me in again to see her. She was induced to do this, more particularly, because of the opinion of her attendant that the tumor could not be removed.

On examination I found the whole abdomen filled with a fluctuating tumor, also her legs were considerably œdematous, and she had become much emaciated. I advised her to submit to ovariectomy at once, but she begged me to postpone that operation for the present and tap her again. I complied with her request and drew off eight quarts of thick mucilaginous liquid. I tapped her again on May 4th, June 14th and July 16th, removing sixteen quarts in the last tapping.

August 20.—Thinks she is as large as before last tapping and consents to removal of tumor. To have castor oil to morrow to move the bowels.

Aug. 22, 11 a.m., Operation.—Chloroform administered, followed by ether; assistance rendered

by Drs. Coulthard and Ellis, of Fredericton. A long incision had to be made, extending two or three inches above umbilicus, to get out the solid portion of the tumor, which weighed eight pounds, and was so firmly adherent to the omentum that about nine inches of the latter had to be ligatured. The adhesions to other parts were unimportant. About eighteen quarts of fluid matter were got away by tapping, making the whole tumor about forty-four pounds in weight. It grew from left side. Pedicle secured by clamp externally and sutures put in. Stump powdered with salicylic acid and wound dressed with carbolized oil, cotton wool pad, and bandage being applied over all. Half a grain of morphine suppository given after coming out of ether.

Aug. 30.—Wound has been dressed every day as at first. Temperature reached more than 100° F. only once since operation; 100.5° F. on second day. Has not suffered much pain; taken five or six opiates; no vomiting; sutures were all removed yesterday.

Sept. 2.—Doing well, but bowels have not been moved till to-day, although she has had several enemata during the last few days. A dose of castor oil yesterday, followed by another enema this morning, has had the desired effect.

Sept. 7.—Clamp came off this morning. Doing well.

Sept. 12.—Is up, dressed, and going about the room.

Sept. 18.—Has been down stairs the last two or three days. Some granulations still at site of stump; nitrate of silver applied.

Sept. 27.—Wound healed; has been out of doors.

Nov., 1884.—Has been living in Boston the last five or six years, and has been in good health ever since operation.

CASE II, March 21, 1878.—Mrs. R. D., æt. 49, mother of four children, youngest nine years of age; husband living. Health generally good till one year ago, when she felt a lump in hypogastrium, accompanied with soreness. During last summer had two attacks of severe pain in abdomen, which obliged her to keep her bed about a week each time. Tumor has gradually, though irregularly, increased up to the present. Catamenia have been somewhat irregular, both as regards time and quantity. For the last month the appetite and general condition have failed, and she

now presents an emaciated and careworn appearance. Has consulted five different medical men in towns of New Brunswick and the State of Maine, who all seemed agreed that she was suffering from a tumor which was "connected with the womb," and gave it as their opinion that it could not be removed. Her family physician called her husband to one side just as they were starting from home to consult me, and told him that if she was operated on she would be brought back a corpse.

On examination I found a large hard tumor occupying the whole of the lower abdomen, somewhat irregular on its surface, and at one or two points indistinctly fluctuating. Slight resonance in left lumbar region; dull elsewhere. Per vaginam: os tincae felt directed somewhat posteriorly, and sufficiently patulous to admit the tip of forefinger. Fundus of uterus anteflexed, and tumor pressing closely down upon it; the two seemed to move together more or less in all directions. Sound could be passed only one inch. When the tumor was however lifted well upwards by Dr. Coburn, of Fredericton, who assisted me at the examination, I could enter sound the normal distance by directing it well anteriorly, and I then found that the uterus and tumor could be moved more or less independently of each other. On aspirating tumor at a point which seemed to be more fluctuating than the rest, a small quantity of thick mucilaginous fluid was got. I therefore diagnosed an ovarian tumor, and advised operation. While resting after her long journey for a few days, the catamenia came on.

March 31, 11 a.m., Operation.—Chloroform administered, assisted by Drs. Coburn and Ellis. Incision below umbilicus and tumor tapped. Only a pint or two of fluid got away, and I therefore extended incision upwards to above navel. Some adhesions on the front and left side, were readily broken down, and the tumor delivered. Clamp applied to pedicle and secured externally. Sutures; carbolyzed oil dressing, with cotton wool and bandage. Pedicle sopped with tinct. benz. co. Half a grain of morphine suppository after operation.

April 5.—Wound dressed every day as at first. Has required four or five opiates; considerable vomiting for the first thirty-six hours; attributed it partly to the milk given. Since then has eaten

soda biscuit and tea. Temperature has not risen above 99.2° F. since operation. May chew a little beefsteak to-day. Two sutures removed.

April 7.—Abdomen has been considerably distended for the last day or two, and yesterday evening pulse and temperature ran up to about 100° F. No great pain or tenderness, however. All sutures removed yesterday. Patient feels as if bowels ought to be moved, and I therefore ordered oil, to be followed in a few hours by enema.

April 8.—Bowels moved twice with some gripping last night, and I ordered quarter grain suppository of morphine, which caused her to rest well till morning. Pulse 76, temp. normal. Some suppuration in stitch holes.

April 18.—Has done well since last report. As clamp has not come away, and the stump is swelling rather badly, I cut the latter close beneath clamp and took it away. There was no bleeding, as the parts were completely dead.

Nov., 1884.—As far as known, continues well to date.

CASE III, Oct. 24, 1878.—Miss T. R., æt. 18. Health usually good; catamenia always regular since 13. First noticed some enlargement of abdomen last February. Consulted Dr. Holden, of St. John, N.B., in June, who diagnosed ovarian tumor, and treated her first with iodide and bromide of potassium; of late he has put her on tonics. Abdomen has steadily enlarged, till now it measures thirty-three inches around umbilicus. It fluctuates everywhere. No marked change from health in the general appearance, but she has suffered a good deal of pain in part for a few days past. Ordered opiates pro re nata.

Oct. 27.—Has required quarter grain doses of morphine two or three times in the twenty-four hours; vomiting has been somewhat troublesome from it. Pulse 96, temp. normal.

Oct. 30.—Pain not so severe; pulse 108, temp. normal.

Nov. 4.—Pain has subsided; pulse 96.

Nov. 9.—Chloroform given and a vaginal examination made. Cervix uteri was in normal position. Anteriorly, a firm mass filled roof of pelvis. The hymen being perfect, this examination was not very satisfactory.

Nov. 11.—To have half an ounce of castor oil to-night, followed by an enema in the morning.

Nov. 12, 11 a.m., Operation.—Chloroform ad

ministered, assisted by Drs. Holden and Coburn. Incision made, under carbolic spray, four inches long, between umbilicus and pubes. Tumor tapped and about ten quarts of thick syrupy fluid removed. No adhesions. Tumor grew from right ovary. Pedicle ligatured with carbolized silk and dropped in. About half a dozen sutures put in, and dressed with carbolized gauze. Adhesive straps over this, and cotton wool and flannel bandage. Half a grain of morphine suppository, together with quarter grain hypodermically, was required to relieve pain after the operation.

Nov. 15.—Dressing changed for first time under spray. Wound looks well. Has complained a good deal of pain in abdomen and down right thigh since operation, for which she has had two or three opiates per day. This has seemed to keep up some vomiting, but the temperature has only been up to 100° F. once, on the morning of the 13th. Pulse now 104, temp. 99.5° F.

Nov. 18.—Doing well; no opiate since the 16th. An enema brought away some fecal matter and a good deal of wind yesterday.

Nov. 19.—Wound dressed; sutures removed. Small spontaneous motion of bowels to-day.

Nov. 22.—Wound dressed with adhesive plaster. No pus has been seen at any time.

Nov. 29.—Sitting up for last two days. Pulse 100, temp. normal. As bowels have not moved for several days, some citrate of magnesia was ordered.

Dec. 4.—By dint of citrate of magnesia, castor oil, and enemata, a large quantity of hardened feces has been got away during the last few days.

Dec. 14.—Doing well; is about house. Gaining in flesh and strength.

Nov., 1884.—Was married a little more than three years ago, and has since borne two children.

CASE IV, *March 13, 1879.*—Miss M., æt. 27. Came to me from the country yesterday; gives as a reason for not coming before, that the doctor in her neighborhood always told her that nothing could be done for her. As she began to think that death must soon come, she decided as a last resort to consult me. Was generally healthy till six years ago, when she first noticed an enlargement of the abdomen. No distinct lump ever felt. She has steadily increased in size till she now measures seventy-two inches around body at umbilicus, sixty-six inches around waist, and fifty-six from one

anterior superior spinous process of ilium to the other. Has not suffered very much pain, and has had no difficulty with bladder or bowels. The catamenia grew gradually more and more scanty, till they ceased about two years ago. The upper part of her body is extremely emaciated, while the abdominal walls and legs are immensely swollen. Many large veins course over abdomen. The lower end of sternum is pressed so much outwards that it stands at right angles to axis of body. When standing on feet the oedematous abdomen reaches quite down to upper edge of patellae, and when she sits, it rests upon the seat of chair between the thighs. The upper half of abdomen distinctly fluctuates, but the great oedema below prevents my getting this sign clearly. Per vaginam, the hymen acts as an obstacle to a satisfactory exploration. Per anum, a soft doughy mass can just be touched with finger at roof of pelvis. Pulse 120, weak and thready.

March 14.—Thinking it better to tap the tumor, and thus take the pressure off the kidneys and allow them to remove the anasarous condition somewhat before proceeding to abdominal section, I passed in a long curved trocar with point downwards, and drew off seven gallons of thick treacly-looking fluid. The size of patient did not seem much reduced by the operation. At the end of the flow there came away about an ounce of purulent-looking fluid.

March 15.—Patient rested pretty well last night, but complains a good deal of soreness, which she thinks is largely due to my keeping her quiet in bed since yesterday. She therefore asks to be up, as is her custom. I consented, with the understanding that she should not move about the room. Measurement is now sixty-two inches about umbilicus, and fifty-seven inches around waist. Pulse as before. A slight hacking cough, which has troubled her for a few months, has left her since the tapping. This is probably due to removal of pressure from lungs.

March 19.—As there seems to be little or no improvement in patient's general condition, and as she is urgent for an operation, I agree to remove tumor on the morrow; bowels to be freely opened previously.

March 20, 11.30 a m., Operation.—Ether administered, assisted by Drs. Coulthard, Coburn and Ellis. On making incision I found tumor exten-

sively and firmly adherent in front and right side, to abdominal wall; and this, together with the great size of the solid portion of tumor, necessitated a wound reaching nearly from ensiform cartilage to pubes. Several gallons were got away by tapping, and after three or four hours' hard work, the whole tumor was removed. Pedicle was ligated and dropped in, mass being cut away from left side where it grew. A considerable amount of blood was unavoidably lost during the operation, and brandy had to be given both by mouth and rectum while it was going on. Large rubber drainage tube put in at lower wound, and sutures introduced as usual. Operation was done under carbolic spray, and the wound was dressed with carbolized gauze. Strapping, cotton wool, and bandage over it. Ninety-one and a half pounds of tumor removed, thirty-nine and a half pounds constituting the solid portion. 6 p.m.—Pulse feeble, and occasionally intermittent; a good deal of restlessness. Two drachms of laudanum and half an ounce of brandy given in water by the rectum. 7 p.m.—Sleeping quietly. Pulse rather better.

March 21, 9 a.m.—Pulse 140, feeble, but regular. Extremities warm. Has had brandy, milk and egg, by both mouth and rectum during night. Urine drawn; it looks well. 12 m.—Pulse 148. Considerable serous discharge on dressings, which were therefore changed. 3 p.m.—Pulse more feeble. Some delirium. 4.30 p.m.—Pulse absent at wrists. Extremities growing cold. 9 p.m.—Died. Abdomen examined; no hæmorrhage.

CASE V, *March 28*, 1883.—Mrs. A. G., æt. 50. Multipara. Has not been very strong since marriage, thirty years ago. Had a "fever" when pregnant seven months with first child, and miscarried at eight months; child living. Thinks she has never entirely recovered from the effects of that illness. Has had more or less dysuria for years, though urine, she states, generally looks healthy. More troublesome than ever since two years ago, at which time she thought there was a tumor in the vaginal passage. Eighteen months ago, underwent an examination by a physician of a neighboring town, who told her that she had a "fibroid" tumor of size of fist at the back of womb. Catamenia have been tolerably regular, though she sometimes has gone beyond the four weeks. Appetite has been poor of late. Abdomen is now about size of that of a woman at full term. This

enlargement is due to a hard irregular mass, most prominent on right side. Very little if any fluctuation can be detected in it, though in parts it seemed somewhat elastic. Per vaginam, uterus felt at right anterior pelvis. Sound enters normal distance. A mass, similar to that felt through abdominal wall, and apparently continuous with it, found pressing down well into pelvis posteriorly. Uterus moved independently of tumor. Lumbar and epigastric regions alone resonant on percussion. Pulse 84, temp. 99° F.

April 6.—Catamenia appeared the next day after last examination, being the proper period for them. Pulse 88, temp. 99.

April 9.—Took a cathartic yesterday evening, preparatory to an operation, and had two loose stools accompanied with some griping. Paregoric relieved latter. Pulse 92, temp. 100.

April 11, 12 m., Operation.—Chloroform administered, followed by ether. Assisted by Dr. Coburn, and Mr. J. G. Owens, my medical student. Carbolic spray used. Incision from just above umbilicus to near pubes. Tumor tapped and about three quarts of thick material got away. The solid portion, weighing about seven pounds, was then removed. No adhesions of importance. Tumor grew from left ovary. Pedicle ligatured with silk and dropped in. Wire sutures. About a dozen catgut ligatures had to be applied to various bleeding points of wound in abdominal wall, long continued pressure with forceps not controlling the hæmorrhage. Carbolized gauze, etc., as in cases 3 and 4. Suppository, containing half a grain each of morphine and ext. belladonna, administered. On examination of tumor nearly a pint of thick, flaky, purulent matter found scattered through its solid portion.

April 12, 9 a.m.—Rested fairly. Pulse 92, temp. 100. Vomited only once. 9 p.m.—Pulse 96, temp. 100.8.

April 13, 8 p.m.—Pulse 76, temp. 99.4. Some menstrual flow appeared to-day.

April 14.—Pulse 72, temp. normal. Wound dressed under spray.

April 19.—Bowels were moved by enema two days ago. Sutures removed to-day under spray. Wound about healed. Pulse 76, temp. 98.6.

April 25, a.m.—Patient sat up for an hour last evening; while up she suddenly got chilly, and was obliged to go to bed at once and be covered

up warmly to avoid a rigor. Some pain was complained of in left side running up towards axilla, which was relieved by half a grain of morphine suppository. Not much pain this morning, but pulse is 100 and temp. 101.4. 6.30 *p.m.*—No great pain to-day. Pulse 110, temp. 103.4. Wound is all right, and there is little or no distension in, or marked tenderness of, abdomen. Nothing wrong per vaginam.

April 27, 9 a.m.—Has had half a grain of morphine suppository and rested fairly well. Pulse 104, temp. 101.4. 8 *p.m.*—Pulse 100, temp. 103.2.

April 28, 9 a.m.—Has perspired rather freely this morning. Pulse 80, temp. 99.2. 8 *p.m.*—Pulse 84, temp. 101.6.

April 29, 10 a.m.—More free perspiration last night. Pulse 76, temp. 98. 9 *p.m.*—Sweating continues. Pulse 72, temp. 98.

May 2.—Has been doing well since last report, and has returned to solid food with a relish.

May 12.—Left for home, about 90 miles away.

Nov., 1884.—As far as I am aware, has remained in good health up to the present time.

REMARKS.—There are several points in the above cases which are worthy of notice. In the first place, in four out of five the long incision had to be made in order to get out easily the solid portion of the tumor. The favorable result in three out of the four would rather indicate that the increase of risk is not so much as generally believed when the incision is extended above the umbilicus.

Secondly, the much abused clamp was used to secure the pedicle externally in the first two of these, and they both did exceedingly well.

Thirdly, the presence of pus in Cases 3 and 5, showed that before long there would have been an escape of matter into the peritoneal cavity, and consequent death.

Fourthly, the immense size of the tumor in the patient who died. I removed at least 147½ lbs. from her in six days; and supposing the sac re-filled to the extent of 20 lbs. during those days, the tumor must have originally weighed 127½ lbs. I may mention that Dr. Thomas Keith, to whom I related this case last April, considered 20 lbs. a liberal allowance for its increase during that period. My own impression is that I gained nothing by the preliminary tapping in that case, for I think that she was if anything weaker *after* it than *before* it; and I attribute her increased weakness (whether

rightly or wrongly) to the rapid re-filling of the emptied cyst, causing a great drain upon the nutritive principles of the blood. If I should ever meet with such an enormous tumor again, I would at once proceed to ovariectomy.

Finally, the feverish turn which occurred in Case 5, was, I believe, due to some kind of blood poisoning, causing a short continued fever. I had noticed on several occasions, both before and after its occurrence, a foul smell in the hall adjoining her room. I had called the nurse's attention to it, but neither she nor I could ascertain the source of it. I can't help thinking that this had something to do with her febrile attack. There was nothing at any time in the wound, or, as far as I could detect, in the abdomen, to account for it. It will be observed that her temperature reached only one evening as high as 100.8° F., in the first week after the operation, while during the second week it had been normal. It could therefore be scarcely possible after such a period of favorable convalescence, that the operation had anything to do with the febrile attack. I may say that this patient was one of those who are very gloomy, and she fully expected not to live beyond the ninth day. She disclosed this fact to me only after that day had passed, although she had me sent for hastily on several occasions during the 8th and 9th days, imagining that her time was at hand.

I may further observe that in all these cases I had no skilled nurse to look after the patients, not even one who had done other kinds of nursing; so that it is evident one may get very fair results in ovariectomy in remote districts where such are hard to procure, as well as in hospitals peculiarly equipped for such operations. I am free to admit, however, that the assistance of a nurse accustomed to the care of such cases, would lessen materially one's own anxiety and the amount of attention required to be given to them.

A CASE OF DOUBLE NARCOTIC ADDICTION.—OPIUM AND ALCOHOL.—IMBECILITY—RECOVERY.

BY J. B. MATTISON, M.D., BROOKLYN, N.Y.

Through the courtesy of Drs. T. Gaillard Thomas, of New York, and Wm. Bayard, of St. John, N.B., there came under the writer's care last

year a case of combined opium and alcohol taking, presenting a history and result of such importance as probably to render its recital one of interest to the readers of the LANCET.

Mrs. —, of Canada, æt. 34, in the summer of 1881, passed through her second accouchement during the eighth month of gestation. Her recovery was tedious, involving four to five months, during which she had much discomfort from alvine torpor, and also underwent an operation for the relief of fistula in ano. The latter was attended by severe pain, to relieve which her medical adviser gave morphia hypodermically, and supplying her with a syringe instructed her and the attendant in its use. This was in July, and the initial dose of the morphia was $\frac{1}{8}$ of a grain, repeated three or more times daily, when the pain was severe. She made a fair recovery from this illness, except that the power of her lower limbs was largely lost, due, it was thought, to the morphia—which she had steadily taken—and a lack of active exercise. She had now become a confirmed habitué, and during the next two years used her opiate in increasing quantity and frequency, often repeating it every three or four hours.

During the autumn of 1883 she came under the care of a medical gentleman who was called to relieve her of severe abdominal pain and nervous derangement. Prior to this time no attempt had been made to abandon the morphia. Her new medical adviser, appreciating the situation, strongly urged an effort in that direction, but without success. Her condition had steadily grown worse, aggravated as it was by an inordinate use of brandy, of which she took at times from 12 to 16 ounces daily. From October, 1883, her mental and physical decline was marked, the most prominent symptoms being anorexia, insomnia, nausea, incessant thirst, subsultus, loss of memory, delirium, hallucinations and partial imbecility. Her physician now insisted on stopping her stimulants, and succeeded with the brandy, while the morphia, which had been increased to several grains, three to five per diem, was reduced to one or two injections daily. Despite this treatment her mental and physical status steadily deteriorated until she became completely imbecilic, and in this condition, on December 21, 1883, she came under the writer's care.

So weak was she prior to leaving home that

some of her friends deemed it hazardous to make the effort, fearing she would not survive the journey, but under the watchful care of Dr. Bayard, it was safely effected. Her physical debility on arriving was so great that she was carried from her carriage. Mentally she was a wreck. Delusions were prominent, and hallucinations of sight, sound and touch almost constant, that of touch being especially marked, patient fancying bugs and reptiles crawling over her. Her expression was idiotic; she was utterly unable to converse intelligibly, and her voice in speaking speedily sank to a whisper and was lost. In fact such mental ravages from opium we never met. Physically, she was partially prostrated, pulse frequent and feeble, marked anorexia, furred tongue and alvine torpor; in fine, all the symptoms before noted except delirium and subsultus. During her coming, in order to maintain her strength, she had taken milk punch freely, and was given one or two half grain injections of morphia daily. Such was her status on arrival. There was no history of hereditary insanity. The case seemed clearly one of profoundly pernicious results from her double addictions, aggravated by a laudable effort to remove the cause. This being our belief, the prognosis was favorable, an opinion endorsed by Dr. John C. Shaw, Superintendent of the King's Co. Insane Asylum, who was called in consultation, and verified by the result, as the further record of the case will show.

As a prelude to active treatment the patient was given a mild mercurial which acted well. No alcohol was allowed from the outset, and at the end of a week the morphia—which previously had been given in small doses by mouth at bed-time—was quite abandoned, and reliance placed on large doses of Indian hemp to secure sleep. As tonics she was given daily seances of electricity, with syr. of the hypophosphites of iron, strychnia and quinine, in two drachm doses, *ter die*, and full feeding. The good effect of this *regime* soon declared itself, for in less than a fortnight, signs of improvement presented. The earliest of these were mental. The delusions lessened and the hallucinations departed, the last to leave being those of touch which persisted for some time after the patient was able to realize that they were only the vagaries of her disordered brain. With this amendment came a better brain status in other

ways. The imbecilic look gave place to one of increasing intelligence; the power to converse rapidly returned, and within six weeks all mental aberration had vanished. Meantime, the physical condition gradually improved, though not so speedily as the mental. The appetite was slow in returning, but her muscular strength, especially in the lower limbs, the loss of which for two and a half years, had prevented exercise, increased steadily, so that at the end of eight weeks she was able to take walks, drives, go shopping, attend church, etc., in fact, more out of door exercise than she had enjoyed for years. Her improvement in every way was notable and persisted with little interruption until March 4—nearly eleven weeks from the date of her coming—when she left our care. Tidings, direct and indirect, of late received, report her doing well.

This case presents several points worthy of detail. Its origin affords added proof in support of views expressed in "The Genesis of Opium Addiction," *Detroit Lancet*, Jan. 1884. But it must also be said that, in our judgment, the course of the medical gentlemen in supplying this patient with a hypodermic syringe and solution of morphia, with instructions for self-taking, unless absolutely unavoidable, was—to put it mildly—exceedingly indiscreet. Such action and advice are almost certain to end in addiction; the effect, even under professional attention, is, too often, disastrous, and the chance of escaping, when left to caprice of the patient, is small indeed. We believe that patients should *never* be allowed to give themselves injections, if at all possible to avoid it.

When her initial illness ended, this patient was an opium habitué. A much more limited time than that will often suffice. We have repeatedly known as many weeks to beget addiction, and the most marked examples of this were among those in whom it might be supposed the least likely to occur—physicians. Increased experience serves only to strengthen the writer's opinion, as expressed in a paper on "Opium Addiction among Medical Men," that "any physician using morphia, daily or oftener—especially hypodermically—for four weeks incurs great risk of becoming an habitué; indeed we think a still shorter usage might, with some, prove a snare." This case adds another to the instances in which addiction to one narcotic tends to excess in another. While these are infrequent

as compared with those in which one is used, they are sometimes quite notable. We recall that of a Canadian gentleman who some time ago consulted us, who had taken for several years 10 to 20 grains of morphia subcutaneously, 60 to 90 grains of chloral, and 1 to 2 pints of whiskey, daily. Physical examination disclosed organic heart lesion, and care of his case was declined. As a rule, the ruinous results exceed those of a single addiction, while the prospect of permanent cure is always less hopeful. In our patient the pernicious effect on the brain was notable—more so than we have ever seen. While deviations from normal cerebral action are sometimes observed in cases of confirmed opium taking, it is rare that they are so pronounced as in this instance. Doubtless they were aggravated by the alcohol, yet morphia was the main factor. And it is of interest to note that the attempt at renouncing the narcotics intensified the mental disorder. Obersteiner—*Brain*, Oct., '82—demurring to Levinstein's statement that the psychical disturbances caused by morphia cease within a few hours, affirms that "mental diseases arising in the course of morphinism are of the most intractable kind when once fully developed. Not only do they not disappear on depriving the patient of morphia, but they then usually get worse."

This case tends to prove the latter part of his statement. As one medical gentleman informed us—"The condition in which you saw her was the result of the addictions aggravated by the attempt to quit them." But the mental disorder was *not* of the "most intractable kind," for improvement was prompt and progressive, much more so than anticipated, as it was thought several months rather than weeks would be needed to repair the damaged brain.

Regarding alienation caused by opium, Obersteiner thinks it frequent, asserting that "a man who consumes large quantities of morphia during a number of years will display many nervous symptoms, and that the continued intoxication attacks the psychical much more constantly than the somatic life." He further states: "The degree of mental aberration arising from protracted use of the drug is very variable. There may, indeed, be individuals who retain their power of mind in spite of it, but the number is much greater of those who betray a marked alteration of their intellectual and

moral life; and in not a few cases finally the point of distinct aberration is reached. This usually consists of a depressed state, with suicidal tendencies, occasionally with violent excitement and hallucinations;" and he sums up his views with the statement that "In most cases the protracted use of morphia in large doses is followed by psychical alterations of a lasting nature, which may amount to decided insanity."

With these opinions we are not in full accord. Our experience has been much more favorable. We have observed many cases of opium addiction, among them those who had taken morphia in large amounts for several years, yet the number with marked mental derangement has been small. Depression has been common; so, too, irritability of temper; but we recall only one instance in which suicidal or homicidal tendency existed, and but a single case that we deemed "decided insanity." Far oftener physical symptoms presented. In some form, these have been almost constant, so that, on this score also, our observation has been at variance with Obersteiner.

Regarding treatment, one point deserves special mention—that is, the effect of Indian hemp in large doses. In this instance it quite maintained the power ascribed to it by Moreau of removing hallucinations. Again and again, often by the patient, was this noted. Its hypnotic action also was very satisfactory. As a soporific, in ex-opium habitués, cannabis indica is of great value. They may be peculiarly susceptible to its good effect, but certain it is we know of nothing equalling it, and employ it almost exclusively. For details regarding its use, *vide* "The Treatment of Opium Addiction," *Courier of Medicine*, Dec., 1884. Finally, the history of this case is of value as warranting hope of entire recovery under conditions that, seemingly, offer little promise of success.

COCAINE AS A LOCAL ANÆSTHETIC.

BY A. M. ROSEBRUGH, M.D.

Surgeon to the Eye and Ear Dispensary, Toronto.

The surprising effects which have been attained during the last few weeks, with the muriate of cocaine, has led me to collect some facts in regard to it, for the benefit of the general reader.

Cocaine hydrochlorate is prepared from the

leaves of the *erythroxylon coca*. The plant grows wild in the mountains of Peru and Bolivia in South America, where it is used instead of tobacco. It is estimated that thirty millions of pounds per annum, are consumed by the natives who chew the leaves made into a ball mixed with lime. When used in moderate quantity, it is said to increase nervous energy, enliven the spirits, and enable the person to bear bodily exertion, exposure, and want of food to a surprising degree.

The physiological action of the alkaloid (cocaine formula $C_{17}H_{21}NO_4$) is apparently identical with that of theine, and caffeine. The alkaloid was discovered in 1855. In large doses it produces cerebral excitement, complete paralysis of sensibility, tetanic spasms, and death. It paralyzes the entire posterior column of the spinal cord and the entire system of peripheral sensory nerves.

The hydrochlorate of cocaine has been used for over two years for the purpose of reducing the sensitiveness of the larynx, but it was not until about the first of September last that its anæsthetic effect upon the conjunctiva and cornea was discovered. The honour of this discovery is due to Dr. Koller, a young physician of Vienna. The discovery was announced at the meeting of the International Ophthalmological Society, held in Heidelberg September 15th and 16th, the report of which appeared in the *N. Y. Medical Record*, October 11th, and in the *Ophthalmic Review*, a little later. Since then the anæsthetic properties of cocaine in ophthalmic as well as in some other branches of surgery has been very thoroughly tested, and with the most gratifying and surprising results. Up to the present, the only salt of cocaine used is the hydrochlorate which is used in solution of from 10 to 20 grains to the ounce. For producing anæsthesia of the conjunctiva and cornea, from two to four drops are applied every three or four minutes until from eight to twelve drops are used. Partial anæsthesia commences within two minutes of the first application, reaches the maximum in about fifteen minutes, and disappears in twenty-five or thirty minutes. Under its influence, the eye-speculum may be introduced, the conjunctiva seized with the fixation forceps, the eyeball fixed in any position, and all the ordinary operations may be performed without pain. When the solution is applied only superficially the anæsthesia does not seem to extend to the ocular muscles or to the iris. Before perform-

ing tenotomy ether for strabismus or for enucleation, the hypodermic syringe is used, and before excising a section of the iris the cocaine solution is allowed to enter the anterior chamber through the corneal wound. I have found cocaine useful in facilitating exploration of the eye. This is of special advantage in treating children and highly sensitive patients. It relieves photophobia and removes the dread of manipulation. Whether or not it possesses actual therapeutic value remains to be seen. It will be at least a valuable adjunct to other remedies.

In addition to its anæsthetic properties, it dilates the pupil and diminishes the power of accommodation. As these effects all disappear in a few hours, cocaine will probably supersede atropine for ophthalmoscopic examinations, and especially so as I find that the eye is more tolerant to the light of the mirror when under its influence.

Cocaine hydrochlorate has already been applied as an anæsthetic and with encouraging results, to the mucous lining of the nasal cavities, the pharynx, the urethra and vagina. Under its influence the actual cautery has been applied to the turbinated bones, the catheter has been introduced into an unusually sensitive male urethra, and operations have been performed upon the os uteri, with little or no pain.

Cocaine has been found to contract the venous sinuses underlying the Schneiderian membrane, hence it is suggested as a remedy in acute, coryza hayfever, and epistaxis. It also exerts a controlling effect upon the painful affections of the eye, as in iritis, in the phlyctenular diseases, and after operations and injuries; and it has been used with success in painful affections of the ear.

The price of the new remedy one month ago was as high as one dollar a grain, but it can now be obtained for 50 cents. The price is still too high to admit of its general use, but in important operations such as iridectomy and extraction of cataract, where general anæsthesia is attended with serious drawbacks, cocaine would not be too dear at one dollar a grain; and even at that price the cost would not be greater than in using the best sulphuric ether.

QUININE AND ERGOTINE.—Ergotine neutralizes the cerebral effects of quinine. Tinnitus may be entirely avoided by combining these two remedies.

COMPOUND FRACTURE OF THE SKULL, ESCAPE OF BRAIN SUBSTANCE, RECOVERY.

BY H. ROSS, M.D., CLIFFORD, ONT.

Permit me to give a few details of a case that occurred in my practice between three and four months ago. R. B., æt. four years, while playing on the lower steps of an outside basement stair at the rear of the dwelling, was struck on the head in the right frontal region by a brick which fell from a second storey window, a distance of eighteen feet. The child fell but rose again almost immediately, ascended the stair and was finding her way into the house, when met by her mother.

I saw the case a few minutes after the accident. The child had vomited two or three times before I arrived, but showed no other symptoms of having received a severe injury. On examination, I found a scalp wound about an inch and a half in length, which had bled freely, and amongst the hair a quantity of brain matter, in all about the size of a large marble. The mother had previously wiped a quantity of blood and brain matter from the wound. In the then excited state of the child, I found it impossible to make a proper examination of the wound, or with any degree of safety to ascertain the extent of fracture, without the use of an anæsthetic. I therefore sent for Dr. Stewart, of Palmerston, to assist me, and in the meantime placed the head in the position most favorable to drainage; applied cold to the head by means of iced water conducted through a bladder by rubber tubes of entrance and exit, provided with stop-cocks to regulate the supply. And as there were no symptoms of depression or shock, except perhaps the vomiting, I gave a sharp purge of calomel and jalap. On the arrival of Dr. Stewart, we chloroformed the patient, and on examination found the fracture to be about one inch longer than the scalp wound and situated three or four lines lower on the frontal bone, owing probably to an oblique position of the head when struck. There still remained debris of brain matter between the edges of the wound, and on closer examination, the strongly pulsating torn end of an artery (a branch of the anterior or middle meningeal, most likely the latter), which had been ruptured by the injury, was seen projecting from between the edges of the

fracture. The lower edge of the line of fracture was found depressed the entire thickness of the skull, and the vessel appeared to be compressed by the edges of the fracture to an extent sufficient to prevent hæmorrhage. It is reasonable to suppose that the depressed edge of the fracture recovered its position to some extent after the injury, partly from its own resiliency and partly from brain pressure, so that the hæmorrhage which had apparently been free at first, was arrested by the pressure exerted on the bleeding vessel by the re-approximation of the edges of the fracture. The peculiarity of this case is, not the recovery of the child, for recovery is not so rare an occurrence, especially in children, after brain injuries with loss of brain substance; but what seems singular in the case is the fact, that with the one exception of vomiting, the child never gave any indication of having received a severe injury of any kind, from the day of the accident up to the present time. She never betrayed the slightest want of intelligence from first to last, and a few minutes after the accident, as well as throughout her confinement to the room up stairs, readily recognized the voices of her associates who were playing on the street below. It seems to me, the only reasonable explanation of the absence of brain symptoms, and one which is concurred in by Dr. S., is that the extrusion of brain substance caused by the continued action of the violence which produced the injury, while relieving to some extent the brain pressure, by carrying with it the already severed artery, also saved the child from the immediate and remote effects of extravasated blood in brain tissue. I need scarcely say, that in the absence of symptoms, and of any spicula of bone which might irritate the brain, we did not interfere with either the fracture or scalp wound, but secured perfect quiet in a moderately darkened room, a position favorable for drainage, the continuous application of cold to the head for many days, regular action of the bowels, and the use of cold water dressing to the wound, which healed kindly in a short time; and after a few days it was with difficulty that the little patient could be restrained from playing with the other children when she heard their voices on the street, and for the last two or three months she has been playing about the streets, as lively as the best of them.

CASE OF MOLAR PREGNANCY COMPLICATED WITH PUERPERAL URÆMIA.

BY E. H. WILLIAMS, M.D., C.M., L.R.C.P., LOND.
(Toronto General Hospital.)

N. A., æt. 21, admitted to hospital Oct. 4th, said to be suffering from rheumatism. It was soon ascertained that she was pregnant about three months. A dark, offensive discharge was observed from the vagina. A bath was carefully taken by patient, after which she soon began to flow, somewhat profusely. As she denied anything like labour pains, it was thought the progress might be stopped, and accordingly (the os being only slightly dilated), perfect quiet was enjoined, and full doses of black haw, opium and cannabis indica, administered. It soon became evident, however, that this was of no avail, and a plug, of the kite-tail form was introduced, and replaced by another in 6 hours, which second remained in 8 hours, when the os was found dilated. During this time ergot was given by the mouth, but provoked vomiting after a time. The uterus was then easily emptied of a mass having a feel of placenta, but which proved to be a much hypertrophied decidua containing an imperfectly formed amnion, with a number of black clots beneath it. No trace of what could be called an ovum could be found among the clots or anywhere in the mass. Several semi-organized clots were taken out of the uterus, and $\frac{1}{2}$ a drachm of ergot (F. Ext.) administered hypodermically (into the gluteus). All went well for a while, but that night the patient was unable to sleep, so that small doses of pot. brom. and tr. lupuli. were given. About 2 a.m., however, was called up, and found patient very restless and irritable, trying to get out of bed.

A catheter was used, and about 2 ounces of urine drawn off, which was found to contain about $\frac{1}{3}$ albumen, *sp. gr.* 1011. Pulse 145, and rather feeble; temperature 102½. Hot fomentations were applied over the loins, and more blankets put over her, and a mixture of liq. amm. acet., spts. æth. nit. and fl. ext. jaborandi given. Hot water bottles were applied to feet. Diarrhœa had by this time set in, and was not stopped. For a while perspiration was free, and in the morning she seemed better as regards pulse and temperature, but in a state of semi-delirium, which seemed to lessen towards noon, when she became suddenly comatose, with dilated pupils, stertorous breathing,

etc., and died in a very short time. There was no sign of a convulsion from beginning to end, and from the beginning of threatening symptoms until death (about 12 hours) there were about 7 oz. of urine secreted. She admitted having taken oil of juniper on one occasion to procure abortion. Had given birth to a healthy child 3 years before.

A P. M. Examination was made by Dr. Teskey, and the following conditions found: The *heart* weighed 11 oz., and the valves were healthy.

Lungs, oedematous and congested.

Liver (4 lbs, 8½ oz.) congested, edges thickened, and a tendency to fatty degeneration.

Spleen (16½ oz.) congested, soft and friable.

Uterus (8½ oz.)—no signs of peritoneal or cellular inflammation around uterus. Ovaries and corpus luteum normal. The os uteri was scarcely dilated, but slightly ecchymosed on its inner surface. A few small clots were found on the inner surface of the body of the uterus.

Kidneys,—capsules adherent in places, tissues markedly congested, light and dark streaks running from the centre peripherally. A small abscess was found in the right kidney near the pelvis.

The *cranium*. Vessels of dura mater congested, and a milky appearance of the pia mater at the upper part, the whole brain presented a "wet" appearance.

Considerable serum was found in the subarachnoid space, especially at the base, and also in the lateral ventricles, of which the lining membrane was opaque. The choroid plexuses were much congested. No emboli could be found in the cerebral vessels.

A microscopical examination of the kidneys was also made by Dr. Teskey.

Pathological changes were most marked in the cells of the convoluted tubules. These were found enlarged, angular, and mostly separated from the walls so that many had fallen out in the process of mounting, leaving the tubules naked. The cell contents were markedly granular, the nuclei not readily seen, and the lumen of the tubes small, irregular, and choked by broken epithelial cells in many places, especially near the boundary area. The glomeruli were somewhat enlarged and hypernucleated with thickening of Bowman's capsule. The inter-tubular tissue was also increased in thickness and nucleation. No marked changes were found in the tubules of the pyramids.

THE NEW LOCAL ANÆSTHETIC, HYDROCHLORATE OF COCAINE—EXPERIMENTS WITH CAFFEINE.

BY R. A. REEVE, B.A., M.D.

Senior Ophthalmic and Aural Surgeon, Toronto General Hospital—President, Toronto Medical Society, etc.

It is not surprising that the virtues of a drug which is at once absolutely non-irritant and equally anæsthetic to the urethra and conjunctiva, the cornea and drum-head, and the mucous membranes of the larynx, naso-pharynx, vagina, etc., should be promptly and widely tested and heralded. The various indications it fulfils will be so apparent as hardly to need specifying. The following cases illustrate in part its potency, and one is cited, not without interest, in which it proved useless. The solution used was of four per cent. strength, the two per cent. having been found too weak, as a rule, for operations upon the eye.

CASE 1.—J. A. Toronto General Hospital, Iridectomy, Nov. 11th. Four applications in fifteen minutes; operation begun five minutes after the last; no pain,—“just felt the doctor was doing something.”

CASE 2.—J. T. T. Sclerotomy for secondary glaucoma,—drug useless. Six instillations (of several drops) in twenty-five minutes; operation attempted five minutes later, but patient not tolerating the use of knife or forceps, chloroform had to be used. The patient was a very nervous subject, and there was possibly idiosyncrasy in addition to evident hyperæsthesia.

CASE 3.—Mrs. McC. *Operation for secondary cataract*: solution applied three times in ten minutes; discission ten minutes later. The patient, a nervous lady, said she “felt not a bit of pain.”

CASE 4.—Mrs. T. *Mucoccele; Bowman's operation*: three applications on punctum and inwards; canaliculus slit as far as caruncle without pain, and into sac with but little; pupil moderately dilated, but contracting to light and on accommodation.

CASE 5.—Mrs. M. *Iridectomy for inflammatory glaucoma*: five instillations upon upper margin of cornea in fifteen minutes; five minutes later, section at sclero-corneal junction not felt; solution dropped upon wound holding knuckle of iris; two or three minutes later segment of iris excised. The patient, a delicate nervous lady, said “she only felt the operation a little.”

CASE 6.—M. C. æt. $3\frac{1}{2}$ years: *Staphyloma of cornea*: Fifteen minutes after a single instillation, the cornea was incised, without complaint.

CASE 7.—Mrs. C. The galvano-cautery was applied to several points on the septum and turbinates after the use of the solution, without other discomfort than fleeting neuralgia of superior dental nerves.

CASE 8.—Ulceration of larynx. A two per cent. solution gave marked relief of irritability.

CASE 9. — *Inflammation of auditory meatus*. Solution dropped into ear; tenderness and pain sensibly relieved—"a sort of numbness."

CASE 10.—E. L., Toronto General Hospital. *Iridectomy*. Five applications in forty minutes; operation ten minutes after the last; section of cornea not felt; the seizure and excision of iris gave some pain.

CASE 11.—F. G. H. *Pterygium*. Four applications; abscission and suturing practically painless.

CASE 12.—N. McL. *Strabismus*. Four instillations in fifteen minutes; tenotomy five minutes later; moderate pain caused by traction upon muscle with hook, but none in cutting tendon; pupil not dilated in thirty minutes.

Under cocaine, extraction of cataract is not more painful than iridectomy; and more frequent droppings or stronger solutions than the four per cent. may be found to anæsthetize the iris—a safer plan apparently than injecting into anterior chamber. Cocaine may be used to prevent (or mitigate) the after pain of operations in various parts and lessen risk of secondary inflammation. It will doubtless prove valuable for relief of pain, photophobia and spasm of orbicularis from corneal irritation, as well as of reflex ills elsewhere, of kindred origin. The writer has been disappointed in not finding an 8 or 10 per cent. solution of the alkaloid itself in oleic acid anæsthetic to the skin; but the aqueous solution of the salt can be utilized hypodermically for local anæsthesia, to some extent at least. In solution or unguents of various strengths, it should allay the pain of burns, &c., and the itching in some skin diseases.

EXPERIMENTS WITH CAFFEINE.—Influenced by the alleged identity of the general physiological, if not therapeutical, effects of caffeine and cocaine, the writer was led to test the former, hoping that it also might prove to possess local anæsthetic

properties; but a four per cent. solution failed to appreciably lessen the sensitiveness of his own conjunctiva. Bearing in mind that caffeine is only one-sixth of the strength of cocaine as regards systemic effects, a much stronger solution of caffeine* was next tried, namely; twelve per cent. on the patient, case 1, in whom the anæsthetic properties of cocaine (4 per cent. sol.) had been quite decided; but the conjunctiva remained sensitive, and grasping it with forceps caused pain. This would seem to shew that caffeine is not a local anæsthetic; a fact to be regretted, because it can be had pure and cheap, and the supply is unfailing, while it would seem good coca leaves are seldom imported.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—To save other medical men from sharing the fate of Dr. Rabbeth, of the Royal Free Hospital, London, who recently lost his life by sucking through a tube the secretions from the trachea of a diphtheritic patient upon whom he had performed tracheotomy, I communicate to you the following. A few weeks ago I performed tracheotomy on a little girl about eight years of age, for relief from the consequences of acute laryngitis. Three days after the operation an attack of broncho-pneumonia supervened, and the secretions became so copious and were at the same time so tenacious, that it was found impossible to keep the tracheotomy tubes clear, and to prevent suffocation in a terrible paroxysm, I was obliged to withdraw the tubes entirely and trust to the larger opening thus secured for respiration and the escape of the secretions. After the removal of the tubes respiration continued very imperfect and labored, owing to a large quantity of mucus still remaining in the trachea, and for the extrusion of which the patient could not muster sufficient expulsive force. At this juncture I went to my office, a short distance, for an India-rubber bulb and tube, with which to suck out the accumulation, leaving my partner, Dr. Henderson, and a couple of students with the patient. During my absence, another violent paroxysm of suffocation came on, and Dr. H., by means of a rubber tube, sucked out some of the mucus, and one of

*Though bought from a reliable house it may prove on analysis to be impure

the students did the same thing. Nothing more was thought of this until about three days after, when Dr. H. complained of a sore throat, the parts being highly inflamed, dark in color, and covered with diphtheritic patches. He continued very ill for eight days, and some part of the time fears were entertained as to the result. The student, a day or two later, was taken in a similar manner, though not so severely, and was a week sick. As the rubber bulb would not draw sufficiently to be effective, another means was thought of, as it was evident that the expulsion of the secretions would for a long time require external aid.

The aspirator came next to our minds, and on trying it we found that we had all we could desire. The needle was removed and a small rubber tube, about eighteen inches in length, was attached. Whenever the secretions collected so as to be troublesome, the tube was inserted through the wound into the trachea, the bottle exhausted, the stop-cock turned so as to open the entrance, and powerful and effectual suction was at once accomplished. As soon as the bottle became filled with air, it was again exhausted, the stop-cocks shut, and the apparatus thus prepared kept at hand ready for use. For several days and nights this contrivance was kept in almost constant demand, and most undoubtedly saved the patient's life.

This is not worthy of the appellation of a "new discovery," but it certainly is a new application of a most useful instrument, and one that should never be forgotten for cases requiring this kind of treatment. Valuable lives have been sacrificed by the act of sucking secretions out of diseased throats; and notwithstanding all the cautions against the practice given by our best authors, ambitious and impulsive young practitioners will occasionally risk their lives by performing it. In a late number of the *Brit. Med. Jour.* there is a cut showing the construction of an instrument for use in such cases, consisting of two rubber tubes connected by a hollow glass bulb for receiving the matter as it is sucked out, and to one end is a mouth-piece attached for the operator. But all this is useless, as long as we admit the germ theory of contagion; the air from the diseased parts, no more than the secretions, should pass into the mouth and throat of another. With the aspirator used as I have pointed out, all danger of contagion is avoided; by the use of a large bottle a more powerful suc-

tion can be exercised than can be by the mouth; and by regulating the stop-cock, it can be made to act powerfully or feebly, can be suddenly started and stopped, and the whole apparatus kept ready for instant use. Better than turning the stop-cock every time one wishes it to act, while sucking out collections of mucus, is to compress the tube between the thumb and finger with which it is held; for the suddenness with which it can thus be made to act renders it far more efficient in picking up partially hardened and isolated portions. The aspirator, then, should be one of the instruments of the laryngotomist, and of every one who attends cases in which matter has to be removed from the larynx and windpipe by external force.

Yours truly,

THOS. R. DUPUIS.

Kingston, Nov. 17, 1884.

[A writer in the *London Lancet*, Nov. 8th, 1884, after claiming to have used the aspirator in this way during the past nine years alludes to the defects in the apparatus owing to the air being drawn into the trachea by the side of the suction tube, and recommends the addition of a piece of wash-leather about 6 x 6 to the tube. A piece of vulcanite tube is passed through a small hole in the centre of the wash-leather, which is tied firmly. The suction tube is then passed through this and into the trachea. The wash-leather is moistened and spread over the neck of the patient, and effectually prevents the entrance of air alongside the tube. ED. LANCET.]

PROFESSIONAL ADVERTISING.

To the Editor of the CANADA LANCET.

SIR,—Under the above caption a recent number of the *LANCET* refers to an ex-president of the Nova Scotia Medical Society who occupies half a page in announcing his "Private Infirmary," in Belcher's Farmer's Almanac. It also states that, "this same gentleman issued a circular on the eve of his departure for Europe in which he modestly states that he expects to visit the larger special hospitals of England, France and Germany, and to bring back 'increased stores of knowledge' together with 'new surgical apparatus.'" And now the town of Amherst, N.S., scores another on this count. A medical man who practiced in a village in that section of country and achieved considera-

ble of a certain species of notoriety, finding it desirable to remove, also went to Europe, and in a short space of time comet-like returned with an immense appendage composed of a large number of the letters of the alphabet. He is now astounding the public and the profession by his announcements of "increased stores of knowledge," and the possession of a marvellous 'new surgical apparatus,' costing him "a thousand dollars, and which is unknown to the surgeons of Canada or the United States." By means of this 'instrument' he "will be enabled to successfully carry and apply infallible remedies directly to all or any of the internal organs of the human body."

Apropos of the above in the *Maritime Sentinel* newspaper there recently appeared the following: "Dr. H— successfully removed from the neck of Miss Marney a tumor of three year's standing. The difficulty of removing this tumor was from its being situated among the large blood vessels of the neck." The profession will doubtless be surprised at the surgical and anatomical knowledge possessed by our newspaper reporters, and their simplicity of description for popular reading and edification. The sources from which such articles usually originate are sufficiently apparent and the above is a good illustration. It will not be less surprising when it is stated having been positively ascertained from several practitioners who had been consulted, that the tumor was a very small fibrous growth situated just beneath the skin, about the middle, and below the margin of the left inferior maxilla, and which was "successfully removed" by making an incision at right angles to the jaw bone, leaving a cicatrix more disfiguring than the tumor, which was its greatest discomfort. This matter was allowed to pass unnoticed although perhaps by coincidence an article appeared in the following number of the *Lancet* dealing in general terms with such subjects as the above, and which would have been sufficient to deter any but the most unscrupulous and adventurous from the repetition of such acts.

Nevertheless in a more recent publication of the *Maritime Sentinel*, occurred the subjoined paragraph:—"Dr. H.— successfully removed from the mouth of Miss Austin of River Philip a tumor of four months' standing which had grown rapidly until it was the size of a hen's egg. Miss Austin had just returned from the hospital at Halifax

where they declined to operate. She is doing well." Now this second flagrant violation of the code following so closely upon the other, cannot be permitted to pass, and after careful enquiry into the case, and observing correspondence in the public prints relating to the matter, the following references will place the subject in its proper light. A communication from a medical man to one of the papers calling attention to the repetition of such unprofessional conduct, elicited an answer from an anonymous correspondent, and which was refused publication on account of its "style and inuendoes," and it ultimately transpired that the "reporter" of the "surgical operation" and the anonymous correspondent, was a proxy, prompted and dictated to by the ubiquitous surgeon in question in order to shield himself from the responsibilities of his acts. By reference to the books of the hospital it cannot be found that such a patient ever applied for treatment, and careful enquiry from undoubtedly reliable sources goes to prove that the tumor was a ranula and the "successful removal" consisted in the introduction of the point of the lancet! And now applying the principle of "*similia similibus curantur*," we have decided to introduce the point of the *Canada Lancet* into this benign (?) surgical neoplasm. You have well written it, Mr. Editor, that "our confreres down by the sea are not to be outdone in the matter of advertising."

Yours truly,

A HALIFAX SURGEON.

Halifax, N.S., Nov. 14th, 1884.

[Professional, or rather unprofessional, advertising seems to be a growing evil, and is not confined to any particular Province or locality. One of our city papers recently contained a most glowing account, in black letter heading, of "A Terrible Operation," "A man's tongue cut out to save him from an awful death," performed by one of our own colleagues of the Toronto Hospital staff. When such "things are done in the green tree, what shall be done in the dry"—ED. LANCET.]

Reports of Societies.

CHICAGO MEDICAL SOCIETY.

Reported for the Lancet.

At the regular semi-monthly meeting of this society, Dr. E. Andrews presented a report of the

following cases: Two cases of gastrotomy, two cases of excision of the rectum. Remarks on litholopaxy, and exhibited a new instrument for varicocele.

Dr. S. V. Clevenger read an elaborate treatise under the head of "Political Abuse of the Insane."

Drs. B. and J. Bettman read interesting papers on hydrochlorate of cocaine, illustrating its use in ophthalmic and nasal surgery. The physiological and therapeutical effects of the alkaloid may be tabulated as follows:

(1) Hydrochlorate of cocaine is a powerful local anæsthetic, not penetrating in nature, rapid in its effects, which however are only temporary.

(2) It is a mydriatic, the effect of which is regulated by the strength of the solution.

(3) It produces paralysis of the ciliary muscle, the near point receding from the eye—distant vision is not influenced.

(4) By virtue of its benumbing powers it may be classified as an anodyne.

The following cases were cited, where the drug was used to produce local anæsthesia: Operation for dilatation of the nasal duct; removal of a piece of steel from the cornea, the same having been embedded for two days; operation for cataract; cauterization of the inferior turbinated bones; and to relieve the pain in otitis media acuta purulenta, in each of which it gave the most gratifying results.

The following report was presented by the Committee on "National Sanitation," and adopted. It is really written in the interest of the National Board of Health of the U.S., and was first suggested by Dr. Montgomery, the Secretary of the Society:

The committee appointed at the meeting of this society, Sept. 15th, 1884, to consider and report upon a series of resolutions presented by Dr. L. H. Montgomery, having reference to national sanitary matters, respectfully report the following: That in the judgment of this Society, the sanitary interest of the United States demands the establishment of a permanent national health authority, which shall have for its main functions the detection of pestilential and epidemic diseases, and the enforcement where necessary of sanitary regulations tending to prevent, abate, or suppress them. That a committee of three be appointed by this Society, to collate facts tending to show the

usefulness and necessity of a national sanitary organization, and to compile the same in such form as may be available for disseminating information upon, and creating an interest in national sanitary legislation. That the said committee be empowered and instructed to urge the importance of national legislation upon the attention of the congressional delegation from Illinois, and fittingly to present the subject to representatives of the people in both houses of Congress. All of which is respectfully submitted.

O. C. DEWOLF, *Chairman.*

Selected Articles.

EXOPHTHALMIC GOITRE—CATARRHAL JAUNDICE—LYMPHADENOMA—CATARRHAL NEPHRITIS—INTERSTITIAL NEPHRITIS—SPECIFIC DISEASE OF THE SPINAL CORD.

CLINIC BY PROF. BARTHOLOW.

EXOPHTHALMIC GOITRE.

This case was also before the class a short time ago. It is a case of exophthalmic goitre, presenting the usual quarternary of symptoms, although the fourth was not so distinct as the others. There are present: protrusion of the eyes, enlargement of the thyroid, which, in this case, however, is not as great as it often is, and rapid action of the heart. The fourth symptom of this affection—dilatation of the vessels—was not so well marked. In severe cases the thyroid gland pulsates with the force of an aneurism. In addition to these symptoms there is, as a rule, marked anæmia. This was a prominent feature of this case.

The treatment which she received, and which acts very favorably in cases of even severe exophthalmic goitre, consisted in the administration of the following pill:—

R. Extracti ergotæ,
Ferri sulphatis, aa gr. xxx
Strychnine sulph., gr. ss. M.
Ft. pil. No. xxx.

SIG.—One three times a day.

There has already occurred a marked improvement, and I have no doubt that by a persistence in this treatment the symptoms will gradually subside.

I also pointed out, when this patient was first before you, that in the treatment of uncomplicated cases of exophthalmic goitre there is no remedy so successful as galvanization of the cervical sympathetic. I have repeatedly seen symptoms of a violent character disappear under the use of galvanism,

the positive electrode being applied in the fossa, behind the angle of the jaw, and the negative on the epigastrium. A current of from ten to thirty cells is used, according to the condition of the patient and the amount of reaction. The stabile galvanic current is the proper one. The applications should be made daily for ten minutes at a time. This will tone up the sympathetic, which is the seat of the disorder; it will moderate the action of the heart, contract the dilated vessels and diminish the size of the thyroid. I am particular in saying that the constant galvanic current will cure uncomplicated cases of exophthalmic goitre, and I must insist on that proposition. There are many cases in which complications exist, the most usual being in the heart and great vessels. Such lesions, being permanent, cannot be removed by such a remedy. On the other hand, there are certain cases which are entirely uncomplicated, in which there is purely a functional derangement of the sympathetic system. That functional derangement is entirely removed by galvanic stimulation.

We must, however, not lose sight of the fact that the treatment is not directed solely to the ganglia of the sympathetic, for if one electrode be placed behind the angle of the jaw and the other on the epigastrium, there are within the circuit not only the cervical sympathetic, but the pneumogastric, the descendens noni and the cardiac branches of the sympathetic.

CATARRHAL JAUNDICE.

In this case the diagnosis is comparatively easily made. Looking at this patient, you see that he is jaundiced; the conjunctiva is very yellow, and the skin has a distinctly yellow tinge. Let us now turn to the history, for the history of every case needs to be very carefully investigated; and in a case like the present, the history may of itself furnish the data for a diagnosis.

Three weeks ago the patient began to feel distress in the epigastrium. Taking but a small quantity of food into the stomach sufficed to bring on a choking sensation, and caused him to feel filled up. There has been more or less nausea and occasional attacks of vomiting, and this was especially marked during the past week, when he vomited six times. The tongue is coated with a thick, yellowish fur, which is especially marked on the left side. The passages are whitish, and entirely wanting in their normal color. I inquired whether the stools were mal-odorous, for, as you know, bile prevents the decomposition of the food, and when the bile is wanting, the food may undergo ordinary putrefactive decomposition, and the stools in consequence, may be very offensive. The bile evidently does not flow into the intestine, and we see that it passed backward into the blood. It being eliminated by the kidneys, as shown by the appearance of the urine.

How much pressure is required in front to make the bile pass back into the blood? It has been ascertained by actual observation, that if there is catarrh of one-half an inch of the ductus communis choledochus, with swelling of the mucous membrane at its termination at the duodenum, this will produce sufficient obstruction to prevent the flow of bile into the intestine, and cause it to pass back into the blood.

There are supposed to be two forms of jaundice, hepatogenous and hematogenous. In the former the jaundice is due to reabsorption of the bile; in the latter to the disorganization of the red blood globules.

In the present case we have a history of gastrointestinal trouble followed by jaundice. We know that these attacks of biliary disturbance are exceedingly common in malarious districts. This man has been living in a malarious section of the country until the past three months. Malarial poisoning may cause jaundice in two ways; first, by producing a catarrh of the ducts, and second, by its action on the hepatic cells. We know that in chronic malarial toxæmia, the hepatic cells are crowded with bile pigment. It is probable that the poison which causes malaria acts directly on the hepatic cells, increasing the formation of pigment, and favoring its deposit in the body. In this case there is a distinct malarial element, which has much to do with the disturbance. This has a practical bearing, for these cases, although they may present no obvious malarial trouble, are not readily cured without the administration of an antiperiodic.

Taking these things into account, we come to the conclusion that this is a case of catarrhal jaundice, and that there is also a malarial element.

Such is the therapeutical diagnosis. What are the most useful remedies? The phosphate of sodium is the most efficient remedy for causing the catarrhal process to disappear, and to favor the flow of the bile into the intestine. It will be given in drachm doses three times a day. In this case it will be advantageous to combine with it the arseniate of soda in the dose of $\frac{3}{16}$ of a grain three times a day. We must not disregard the malarial impression. I will direct the salicylate of cinchonidine five grains three times a day. This is a most efficient substitute for sulphate of quinine in ordinary malarial attacks.

LYMPHADENOMA.

At first sight this case may not seem of much importance, but in reality it is of great importance. There is, as you see, a bunch of enlarged glands on each side of the neck. The axillary glands are also enlarged, and I also find that the area of splenic dulness is increased.

That disease characterized by progressive enlargement of the lymphatic glands, by splenic changes and profound anæmia, is known as lym-

phadenoma. Such cases are progressive, going from bad to worse, and, ultimately, if not properly treated, have but one ending. Is this a case of that kind? At this stage it is almost impossible to say. It may be enlargement of the glands due to strumous disease. I am inclined, for two reasons, to doubt this. In the first place, there is no evidence of strumous disease in any other part of the body, and, in the next place, there is enlargement of the spleen; and the spleen is not only enlarged, but it is firm. Then the characteristic progressive anæmia is not wanting.

Lymphadenoma is a constitutional disease. The gland elements undergo the changes known as hyperplasia and hypertrophy—enlargement of existing elements and formation of new elements.

Various measures have been proposed for the relief of this disorder. It has been suggested that the hypertrophy of the glandular system may be arrested by the extirpation of those first affected. It has been found that if the glands be removed early, the disease being limited to one group, we can prevent its spread beyond the glands first involved, showing that there is something generated in the first set of glands which undergoes multiplication and which gradually affects the glands of the body generally.

The treatment must be both systemic and local, the latter being the most important. Internally, probably more good has been done by phosphorus than by any other remedy. It is best given in $\frac{1}{100}$ grain doses, dissolved in a drachm of cod-liver oil, three times a day. Good effects have also followed the use of the syrup of the iodide of iron and manganese. These may be given in combination with the phosphorus. I have found ergot to do great good in a case now in my hands.

As I have said, the most important part of the treatment is the local treatment. The best local remedy is injection of arsenic into the affected glands. The amount of arsenic said to have been used in some cases is almost incredible, as much as thirty to sixty drops of Fowler's solution having been injected at a time. In practicing the injection, ether spray or a piece of lint moistened with chloroform, is applied, to benumb the skin. The hypodermic needle is then inserted and a few drops of Fowler's solution thrown in. The injections should be practiced on alternate days. Various other things have been used locally. Injection of iodine has been employed, but it is much more painful and less efficacious than arsenic.

What is to be done for the enlarged spleen? Our German colleagues are in the habit of injecting arsenic into the spleen. They do this with apparent impunity and with great apparent good. I might enumerate many other remedies but the most important are phosphorus with cod-liver oil, and the injection of arsenic.

PARENCHYMATOUS NEPHRITIS, PROBABLY SPECIFIC.

The interesting cases now presented have such characteristic symptoms that you can almost make the diagnosis at a glance. The first patient is a woman, 47 years of age. The arteries are atheromatous. The tension of the vessels is very high. This is due not only to the deposit of calcareous matter, but also to hypertrophic thickening of the muscular layer in the walls of the vessels. Observe the expression of the face. The lips are bluish and the face is more or less swollen, and there is some difficulty in breathing. Examination of the heart shows that there is more or less atheromatous degeneration of its valves. Notwithstanding the fact that there is no distinct lesion of the lungs, she has at all times difficult breathing. This is not an ordinary case of asthma. There is also a peculiar cough. There is no reason to suspect hepatic derangement.

Examining the urine, we find that it contains albumen. The specific gravity of the urine is low, the amount of solids excreted small, and the quantity diminished. There is general œdema. There are uræmic asthma, and also headache and other symptoms indicating uræmia. Such is the morbid complexus. The patient has a well-marked eruption on the left chest and mamma. This has a peculiar appearance, and makes me suspect specific disease. There are also cicatrices about the mouth, which have the appearance of having been healed under the action of iodide of potassium. In other words, the kidney lesion is probably of specific origin.

Such being the conclusion, the treatment necessarily follows. As, in all probability, there has been no thorough specific treatment, we shall begin with the green iodide of mercury, in one-eighth of a grain dose, four times a day. If this acts on the bowels, a little opium will be combined with it.

Something must be done to relieve the suffering organ by derivation, either by purgatives or diaphoretics. We shall act upon the bowel in the present instance with compound jalap powder, in drachm doses, every morning. This has an effect, by reflex action, to increase the flow of urine. If this is not enough, pilocarpin, in sufficient amount to act energetically on the skin, will then be given.

INTERSTITIAL NEPHRITIS.

Here is another disease of the same kind, but of a different origin. This woman has not the expression of ill health seen in the other. She is not so pale, notwithstanding the fact that her urine contains a larger amount of albumen. The first woman has been made prematurely old by the specific trouble and the remedies used to relieve it. This patient has general œdema, which, however, is not considerable. The feet are swollen at night and the face is puffy. There is no change in the heart

or vessels, and apparently no alteration in the liver. This is a case of simple albuminuria, but, in order to say what its real nature is, a careful examination of the urinary secretion and a microscopical examination of its sediment will be required. This we have not yet had time to do. The probability is that, as the urine is of low specific gravity, and not diminished in amount, it is a case of interstitial nephritis, and not merely a croupous condition. It is essentially chronic in its course.

As regards the remedies, I shall apply here two which I have found very successful, and which I have repeatedly recommended. These are nitro-glycerine and the chloride of gold and sodium. The latter has the property of checking hyperplasia of connective tissue. The nitro-glycerine has been found by experiment to diminish decidedly the amount of albumen; it lessens congestion and limits the change going on in the kidney. Although nitro-glycerine causes dilatation of the peripheral vessels, it is still true that it relieves congestion. The area of dilated vessels in the kidneys is small as compared with the capillaries of the body, so that the mechanical result of dilatation of the arteries in general must be to relieve congestion of important organs.

This patient will begin with one drop of the centesimal solution of nitro-glycerine, three times a day, and one-twentieth of a grain of chloride of gold and sodium in combination with a simple bitter, as extract of *nuxvomica*. Under this treatment decided improvement should be observed.

SPECIFIC DISEASE OF THE SPINAL CORD.

Here is another interesting case, but, as my time has almost expired, I shall have to go over it very rapidly. You notice the peculiar manner in which he stands when his eyes are closed. It is with difficulty that he can cross one leg over the other. The patellar reflex on the right side is well marked; on the left it is not quite so distinct. He has some pain in the calves of the legs. These first appeared ten weeks ago. He has never had any trouble in vision, and has never had double vision. The trouble in walking has developed within a year. He has nocturnal emissions. There is lessened sensation in the bottoms of the feet.

Now what is the explanation of the rapid development of this case, for these are in large part the symptoms of posterior spinal sclerosis? It has not been evolved in the ordinary manner. The symptoms have developed in an irregular way within the past twelve months. There must be some explanation of the rapid evolution of these symptoms and of their irregularity. This, I think, we find in the condition of the tongue. You see the characteristic mucous patches. In other words, this is a case of specific disease of the spinal cord.

As the spinal cord is in danger, it will be well to use mercurial inunctions in combination with the

internal administration of the green iodide, one-sixth of a grain of which, with one-fourth of a grain of the extract of belladonna, will be given three times a day. A little opium will be added if it is necessary. One drachm of mercurial ointment will be rubbed into the groins and inner side of the thighs every day, attention being paid to the condition of the mouth, as it is important to avoid salivation, for these cases do better if the mercurial impression is not carried so far.—*Col. and Clin. Record.*

ABDOMINAL SECTION IN DISEASE OF THE UTERUS.

Abstract of a lecture delivered at the Jefferson Medical College Hospital, September 15, 1884 by Lawson Tait F.R.C.S.

OVARIAN TUMOR.

Here is a patient who, as far as I can see, is the victim of a disease which is very common with us and I suppose as common with you. At first sight, it looks like an ovarian tumor. The first thing which attracts my attention is a scar from a puncture, and here I see the remains of another puncture of an older date. I next notice the uniform shape of this abdomen. There is a symmetrical uniformity about this abdomen which is suspicious. When you see a perfectly uniform enlargement of the abdomen, begin by suspecting that it is not due to an ovarian tumor. The chances in such a case are greatly in favor of one of three things. In the first place, pregnancy, which you must always eliminate; in the second place, a small tumor with malignant growth and ascitic effusion, which is the most likely of the three; and, in the third place, the presence of a parovarian tumor. I next place my hand on the tumor,—and here let me give a caution. When you are dealing with abdominal disease either for the purpose of diagnosis or treatment, you cannot be too gentle in your manipulations. If at all rough in your manipulations, the first thing you do is to frighten the patient and obscure the diagnosis. The abdominal muscles will be contracted, and you will not be able to learn a great many things which it is desirable that you should learn. If in treating abdominal disease you handle the parts roughly, you run a risk of doing harm. I touch the abdomen gently and I have already learned a good many things. I learn, in the first place, that this certainly is not pregnancy, although I knew that before. I learn, in the second place, that it is not a parovarian tumor. I learn, in the third place, that it is probably a small tumor with a large amount of ascitic effusion. I feel in the lower part of the abdomen a semi solid mass, and above this a mass which is not solid. Our business is to

determine what relation the mass not solid bears to the mass which is solid. Above, we obtain on percussion the resonance of the intestine. There is a matter here which obscures the diagnosis. That is the fact she has been tapped. I get an intestinal note above, and there is evident fluctuation, but from these two factors I cannot positively determine which one of the two conditions is present, and it is a rather important thing to know which we have before giving advice.

The conditions to which we refer are the following: This may be a large cyst which has been emptied by tapping, or it may be merely ascitic fluid. If it is a large cyst which has been partially emptied, or which having been emptied, has become partially refilled, it is a case of multicystic cystoma, which can be dealt with in a satisfactory manner. In the second place, it may be a small cyst covered with a large effusion of ascitic fluid. If this be the case, it will be necessary to engage in the discussion of a number of points before making up our mind. I have looked at the patient's face but find nothing there to guide me. I have examined the pelvis, but I find nothing but negative indications. The uterus is small and tolerably free. On the left side there is a small tumor which may be one of two things, either the left ovary in a state of incipient enlargement, or a small mass of papilloma. This may be a single ovarian tumor and the condition here may be the result of malignant proliferation on the outside of the tumor, or on the parietal peritoneum, or the peritoneal coat of the viscera. It is important to know which of these is the more likely. With a half-full abdomen like this, one cannot pretend to give an opinion. The fluid has been removed and reaccumulation is taking place. Although it is impossible to give a positive opinion, I have a suspicion that the fluid which was removed was not removed from a cyst. There is a small tumor in the lower part of the abdomen, and I think that the fluid which was removed was ascitic and that there is here a condition of papilloma. Suppose it is impossible to come to an exact conclusion, what ought to be done? Open the abdomen in either case; for, unless you are absolutely certain that the disease is incurable, it is, in my judgement, a surgical crime to allow a patient to go to the grave with an abdominal tumor, without an effort being made to save her. This should be done even when papilloma, which is a most unfavorable condition, is suspected.

As soon as an ovarian tumor is recognized, you should refrain altogether from tapping, and immediately remove the tumor. The patient whom we have had before us has been tapped. I do not know whether the fluid removed was ascitic or from a large cyst. My suspicion is, as I have already said, that the fluid was ascitic. At this point some critics might ask "What do you make of

those cases in which tapping was done over and over under the old practice, and sometimes under the new, for some patients will not submit to the radical operation?" In regard to the latter point, there is no difficulty with that now. During the last five or six years I have not had a patient come to me with an ovarian tumor, who has refused to have it removed. I can assure her that the chances are 98 out of 100 that she will get well, no matter what the age, no matter what the appearance of the tumor, and no matter what complication may be present, provided it is not malignant disease and that there has been no previous tapping.

Suppose you get an ovarian tumor, when should it be removed? The arguments are all in favor of early operation. The patient is not distressed with the suffering entailed by carrying around a large mass; she is not subjected to the likelihood of the development of papilloma which we suspect in this case; she is not subjected to the anxiety and worry, especially if unmarried, which her appearance will always cause, and the incision will be shorter than when the abdomen is large. The mortality of early operations is almost *nil*. If the tumor be removed before adhesions form or other complications occur, I believe that the mortality would be absolutely *nil*. My own experience leads me to believe that if the practice were uniform all over the world of removing ovarian tumors as soon as discovered, the mortality would not be one per cent. Suppose that we are certain that this patient was suffering from papilloma, that the disease of which we are so much afraid was developing around the tumor; even if I were certain that such was the case, and I were responsible for the treatment of this patient, I should proceed to the removal of the tumor. The reason for that is a very curious one, and one which I cannot pretend to explain, but the facts of which I am quite certain. I cannot say, without referring to my class-books, how many ovarian tumors I have removed, but in a considerable percentage both of parovarian and ovarian tumors, and also cases of myoma, and also in cases where there has been no tumor at all, I have opened the abdomen, sometimes knowing what I should find and at other times not knowing, and have found this curious velvety, warty condition of the peritoneum. One of the most extraordinary cases which I have ever met with, was one sent to me by Mr. Oliver Pemberton, of Birmingham, whose name is probably familiar to many of you. In this case there was enlargement of the abdomen, supposed by several who had examined her to be a parovarian tumor. As soon as I placed my hands upon the abdomen I was certain there was no tumor, but simply an enormous effusion of ascitic fluid. In such cases as this I never tap, I always make an opening in the abdominal wall large enough to admit the introduc-

tion of two fingers, and obtain an intelligent idea of the condition of the abdomen, which cannot be obtained by gazing at the fluid falling from the end of a canula. There is no more danger in this than in tapping. So far as my own practice is concerned, tapping is absolutely discarded. In the case to which I have referred, I made the abdominal opening, and slipped in two fingers, and at once found that I had to deal with universal papilloma of the peritoneum. I inserted a drainage-tube, and allowed it to remain two or three weeks, and completely cured the patient. She is now in robust health some four years after the operation. In another case, in a woman fifty-seven years of age, I removed a large ovarian tumor. Large masses of papilloma were also found. Two of these, each being larger than the fist, could not be removed, and after the operation could be distinctly felt through the abdominal wall. She is now sixty-five years old in good health, and the tumors have disappeared. It is certain there are two kinds of papilloma, one of which is malignant, and which will kill the patient in a few weeks or months, and another kind which is not malignant, and can be cured by removing the tumor or by opening and draining the cavity. I have submitted pieces of papilloma, some of which were obtained from cases which had been cured, while others had come from cases rapidly fatal, to the most experienced microscopists, and they have been unable to detect any difference between the two varieties. This curious condition, presenting as it does such extremely different features, so far as results are concerned, offers a very favorable field for careful research by pathologists. In this case, even if I knew positively that there was present an ovarian tumor complicated with ascitic fluid and large papilloma, I should still urge that if it is possible to remove the tumor, it should be done, for there is a chance that the patient will be cured.

REMOVAL OF THE UTERINE APPENDAGES.

The next case is one which would involve a great deal of talking, and one of which I cannot speak anything like exactly, for that would involve an intimate knowledge of the past history of the patient. For the purposes of instruction however, I may assume what is doubtless the fact, that this girl's sufferings are real and intense, and that everything short of surgical interference has been employed. I might with advantage talk of a case which I treated in the state of New York, in which the condition was to some extent similar to that of the present case, and in which the history was more completely known. For that matter, a supposititious case might be discussed, for it would be easy to introduce into it those questions which are worthy of notice. This is all the more advisable because we have the tracks of very well cleared abdominal surgery on almost all points

which are under discussion with the exception of one. The patient who has been admitted to me comes under this category. She is twenty-one years of age and has a pronounced crop of acne all over her face. When a woman enters my consulting-room, and I see acne, I always ask if she has been taking bromide of potassium. This is the fashionable drug for every conceivable uterine ailment, and yet I have never heard of any one who was willing to swear that he had ever cured anything with bromide of potassium that was worth curing. Still it is the one pump handle which we have, and we work it pretty hard.

How do you recognize the fact that a patient's sufferings are real? I cannot answer that question. All that I can say is, that never in my experience have I had a woman submit to an operation, without sufficient cause to justify it. Of course, I, as all ought to do, place my statement and views, with what I propose to do and the results of the operation, immediate and prospective, clearly before the patient, and, as I say I have never known a woman to submit herself to the operation without finding sufficient cause to justify its being done. You say this puts the responsibility on the patient. Well, that is what we do in every case. The patient cannot be relieved of all responsibility. A man comes to you with a diseased knee-joint. You lay before him the advantages and disadvantages of excision and of amputation, and then you ask him, "Will you have your limb amputated, or will you run the risks of excision?"

This girl is twenty-one years of age; she has to make her own living, and this is a very important matter, indeed. If a woman comes to you whose husband has a large income, or whose friends are wealthy, the case presents altogether a different aspect. To the rich, luxury always contributes largely to the relief of pain. If a woman, whose husband has ten thousand a year, has a chronic inflammation of the ovaries, she will suffer far less than a woman who has to make her own living and has the same disease. If a woman comes to you stating that for one week out of every four she is unable to work, you are bound to perform an operation for her relief. This girl has gone through a long course of treatment. She suffers at her periods, but at other times is tolerably well. The indications for treatment are clear. If a woman tells you that there is one week out of every four that she cannot work, it is clear that the arrest of menstruation will afford relief. As far as I can judge from the history of this patient, the operation which has been suggested is justifiable. You perform the operation, and what do you find? I have always found disease of the uterus or uterine appendages of some kind. These diseases are far more numerous than you imagine, and it would take a long series of lectures to discuss them thoroughly. On the left side, in this girl, there is

a feeling as though there was a mass. I think that, in all probability, it would be found that the ovaries, like the uterus, are infantile in size and probably adherent. Suppose however, that the appendages turn out to be absolutely healthy; I should still say that the operation was capable of being justified by the history of the case.

What are the results? In the great majority of cases there is an immediate relief from suffering and loss of blood. In some cases the relief does not come immediately; but after a time, in a few cases, relief may not come at all; but this is no argument against the operation, any more than it is against many other operations. Take the operation of cataract. This is not always a success. It is probable that in about ten per cent. of all operations for cataract, suppuration of the globe takes place, and the result may rank as mortality. In other cases escape of the vitreous or some damage to another structure will result in such chronic inflammatory change as to leave the consequential results of the operation so bad that it may be classed as a complete failure. There is no realm of surgery out of which I could not pick abundant illustrations to show that in no other branch is success any greater, if as great, as in that of which I have spoken. Immediately after the operation the patient suffers from the climacteric; but this is inevitable in the life-history of every woman who lives to the age of fifty-two. I do not think that these women, who go through these troubles in early life, suffer any more, or even as much, as those in whom it comes at the natural time. Some do not suffer much, while others suffer a great deal.

So far we have not had any trouble, except from one thing, and this is a distressing one. It occurs after all sorts of abdominal operations, after exploratory incisions, after the removal of one ovary for cystoma, after the removal of both ovaries for cystoma, and after hysterectomy. I refer to the occurrence of acute melancholia. All the cases of mental alienation that I have seen following these operations are seven in number, and all have taken the direction of this most unfavorable form of insanity—acute melancholia. I cannot say that any one of them is likely to recover. I do not know that this is a necessary result in a certain number of cases. I have performed abdominal section some 960 times, and in this number I have met with 7 cases of acute melancholia. Of course, a good many of these cases died, especially in the earlier years of my practice. We may state that acute melancholia occurs in about one per cent. of those submitted to abdominal section. I do not know that anything like this follows other surgical operations. This is the only after-result of an objectionable character with which I am acquainted.

MYOMA OF THE UTERUS.

The next subject which Dr. Parvin has submitted for consideration is that of myoma of the uterus. There are two patients outside, but I do not think that it is necessary to bring them in, for you cannot see anything, and you cannot feel anything. I have examined the patients in the waiting-room. One woman is forty-eight years of age, and does not suffer much from hemorrhage or very much in any way. The tumor is hard, shrivelled, and solid, and thus it is placed in the category of cases in which nature has cured the disease. In all probability, nature will not remove the tumor, but nature has relieved the symptoms and so diminished the size of the tumor by shrinkage that nothing more will be required. The other patient is forty years of age. She has had only two hemorrhages, and it is very likely that she can be tided over the climacteric without any surgical interference. Usually, we do not operate on women for fibroma after the age of forty-six or forty-seven unless it is perfectly clear that the use of ergot combined with absolute rest is insufficient to tide her over the climacteric. When, however, the disease appears in young women, say from thirty-five to forty, or as I have seen it in a girl of nineteen, an important question comes up for careful discussion, and here again the patient must accept a good deal of responsibility in the answer. If a patient spends one week of every month in bleeding and suffering pain, becoming anæmic, restless, and irritable, unable to look after her affairs, and you cannot relieve the sufferings or arrest the hemorrhage except by operation, then this question must be considered. Is it worth while for that patient to go on suffering for a series of years when by an operation, the mortality of which is only four or five per cent., she could be relieved? On this point different men will express different opinions. If I were the patient, I should have the operation done. Holding that opinion, I advise the patient to have the operation performed.

Concerning myoma of the uterus, we have a number of traditions which are being rapidly destroyed. One tradition is that myoma is not a serious thing. We have been in the habit of finding, at our post-mortem examinations, a large number of myomata which have never given any trouble, but I need not say that the tumors which do not give rise to trouble, are not the ones which trouble us. The tumors which cause trouble are the ones which we see. If a tumor gives rise to hemorrhage and pain, the woman consults a physician, who recognizes its presence.

There is another tradition, that the occurrence of the climacteric arrests the growth of the uterine myomata. It is now perfectly clear that a certain class of uterine myoma arrests the progress of the climacteric. Frequently we find women going on for years after the usual time of the climacteric,

without any appearance of diminution in the size of the tumor, or in any amount of the hemorrhage. There is a peculiar kind of uterine myoma which causes but little pain or hemorrhage, but which goes on indefinitely increasing in size, and seems to be unaffected by the climacteric.

In uterine myoma, provided the use of ergot and rest does not give relief, one of two procedures may be adopted. The uterine appendages may be removed and menstruation, which seems to be the immediate process by which the growth is encouraged, arrested. It is a fact established beyond discussion that in the great majority of cases operated on hemorrhage is immediately arrested, and the tumor shrivels up, and may disappear. The removal of the uterine appendages is an operation to be recommended in a certain class of cases. In some cases in which the disease is not arrested by the removal of the uterine appendages, there is the far more dangerous operation of removal of the entire uterus or hysterectomy.—*Med. News.*

TUMORS OF THE BLADDER; CYSTOTOMY—Dr. J. L. Little (N. Y. Surg. Society) presented a number of tumors which he had removed from the bladder of a patient in St. Luke's Hospital, who gave the following history, which was kindly furnished by Dr. Ludlow of the house staff: "James McA., aged forty-nine, married, a car-driver by occupation, and a native of Ireland. His family history is good. About eight years ago he had a sudden hæmorrhage from the bladder while urinating. For two days previous he had micturition and pain at the symphysis pubis. From this time up to one year ago the hæmorrhages recurred at intervals of three or four months, and lasted about as many days. During all this time micturition was not very frequent, and he continued at work. About one year ago the quantity of urine voided steadily diminished for about one week, and then stopped altogether, and it was necessary to resort to catheterization. Since this time he has constantly used the catheter, as he has been unable at any time to pass more than a small quantity of urine, and that with great pain. The desire to urinate has become more frequent. The patient was sent to Dr. Little's clinic at the post-graduate school, by Dr. W. B. Wallace, about two months ago. "On examination, no calculus was found, and it was discovered that the introduction of a sound or a soft catheter was always followed by a fresh hæmorrhage into the bladder. He was able to hold his urine without pain for six or eight hours at a time. The symptoms indicating a growth in the bladder, he was sent to St. Luke's Hospital for an exploratory operation. A consultation was held and the operation advised. An examination of the urine showed pus, blood, mucus and triple phosphates. No casts or shreds of tumor were found.

"On October 27th Dr. Little performed median cystotomy. On introducing the finger, a number of soft tumors could be detected. These were situated at the trigone of the bladder, between, and extending beyond, the orifices of ureters. A number could also be felt attached to the upper surface of the bladder. The situation of these growths being distinctly made out by the finger, Thompson's tumor forceps was introduced, and the tumors were seized and twisted or bitten off from their attachments. It was found necessary to enlarge the opening in the bladder by a slight incision downward toward the prostate in order to introduce the forceps with facility. Twenty distinct masses, most of them seeming to be separate tumors, were removed. These varied from the size of a hazel-nut to that of a hickory-nut. They all seemed to be villous in character. A large number of small pieces, evidently torn off from the larger tumors, were also removed. The surface of the bladder, after the removal of these growths, was left considerably roughened. Two orifices, large enough to allow of the introduction of the tip of the finger, could be felt in the situation of the openings of the ureters. These seemed to be the dilated orifices of the ureters. The hæmorrhage during the operation was considerable, but not enough to be alarming at any time. After the operation was completed, the bladder was thoroughly washed out with hot boro-salicylic acid solution. This seemed to greatly lessen the hæmorrhage. The wound was left open, no tube or catheter being used. During the evening following the operation the hæmorrhage was very free at times. Dr. Hance, the house surgeon, tried injecting a solution of tannic acid without effect; finally he succeeded in controlling the hæmorrhage by packing the rectum with ice, and applying ice-bags over the pubes.

"October 28th.—Patient's condition is good. Temperature 99° F., urine stained with blood." Since the last notes in the history furnished by Dr. Ludlow, and read the society, the patient had been steadily improving, passing all his urine from the penis without pain, free from hæmorrhage, and without recourse to a catheter. The microscopic examination, of the tumor would be reported at the next meeting.—*N. Y. Med. Journal.*

FOREIGN BODIES IN THE EYE—Dr. Agnew, of New York, writes;—*Am. Prac.*—"When a patient comes to you complaining of a sensation as if a foreign body were in the eye, you first examine the eyeball from every point of view. You should then turn over the eyelids and examine their inner surface. And here I am reminded of a source of error to which I would call your attention. A few days ago a case came under my observation which illustrates the point. The gentleman had had occasional attacks of conjunctivitis for a year or more. He had then a sensation as if a foreign

body were in the eye. On turning out the right lower eyelid, all that was revealed to sight was a slight redness of the conjunctiva. But there was something in the way in which the sensation of a foreign body in the eye was exaggerated that made me suspect he had a single inverted eyelash. Ordinarily he felt as if some irritant was there which was tolerable, but suddenly there would be a cramp-like action of the eyelid, the irritation would grow rapidly worse, and the eye would fill with tears, followed by the discharge of a little mucus, and temporary relief. His beard was of a sandy color, his hair was light brown, and his eyelashes were almost colorless. I looked very carefully along the edges of the lids in search of inverted eyelashes, and saw, on the innermost edge of the lower lid, a slight curving of the inner angle. By allowing a tear to gather upon this inner edge, I saw there was a difference in refraction in different portions of the tear, and it soon became evident that a delicate decolorised eyelash was there, which, instead of growing from the outer edge of the lid, sprang from the free edge of its inner border. I turned the lid over, and found that this delicate eyelash, which was between the edge of the lid and the eyeball, had been so long caught in that position that it had worn a little groove in the edge of the eyelid; the spasmodic action of the orbicularis, from time to time, so long continued, had embedded the eyelash in the substance of the lid. I removed it, and no further trouble was experienced. This patient had been treated in Europe for acute conjunctivitis several times, and it is possible that the eyelash was on those occasions the cause of all the trouble. An operation will be required to destroy the follicle which produced the misplaced eyelash. So, when a patient comes to you complaining of a sensation as though there were a foreign body in the eye, between the eyelids and the eyeball, you must first look for conjunctivitis. Whether this be present or not, you should then proceed to examine the eye very carefully to see whether a foreign body be present or not. Scan carefully the whole surface of the cornea and of the scleral conjunctiva, and then turn over the upper eyelid and carefully inspect its inner surface. You may then scrutinize the edges of the lids, as I have described, in order to see whether the source of the irritation be an inverted eyelash."

COMBINED VERSION IN PLACENTA PRÆVIA.—C. Behm (*Med. News*, Aug. 16, 1884) has used combined version in forty cases of placenta prævia, without a single death. This must be regarded as an extraordinarily good result for a condition which ordinarily gives a mortality of forty per cent. Hofmeier has already obtained similar results in the treatment of placenta prævia.

The operation is performed as follows: When dangerous hæmorrhage comes on the vagina should

be tamponed until the cervix is dilated. This being done, and the woman anæsthetised, the whole hand is introduced into the vagina, and two fingers into the cervix. If the membranes present, the operator endeavors to rupture them with the finger, then draws the presenting part (unless it be the buttocks) to one side, at the same time making pressure from without so as to carry the buttocks down until he can grasp a foot. This is drawn through the cervix, so that the breech acts as a tampon on the lower segment of the uterus, and the placenta is pressed against the sides of the uterus. In central implantation of the placenta the finger should be pushed through the centre.

After this version the operator waits for the spontaneous expulsion of the child, or at least complete spontaneous dilatation of the cervix, in order to complete delivery. The duration of labor after version is between one half an hour and eleven hours, the average being one or two hours.

The mortality for the children by this procedure is very great, but the chances for the mother are better. The mortality for the children is, however, no greater than by the old operation.

The causes of the great mortality of the mother under the use of the continuous tamponade is the infection through the blood and other matters adhering to the tampon.

THE USE AND ABUSE OF THE FORCEPS.—Professor Goodell made the following remarks in a recent clinical lecture (*Med. and Surg. Reporter*, June 14th): Tears of the perinæum will occur whether the physician uses the forceps or not, but in the majority of cases they come from the use of the forceps, or rather from the abuse of the forceps. Let me give a piece of advice to you as young men. When the proper time comes put on the forceps and boldly bring down the head, but when it begins to bulge the perinæum, take off the forceps. I do not think that any of you are competent to deliver the head over the perinæum with forceps. The temptation is to turn the head out too quickly. If you take off the forceps you will rarely have a bad tear, and if it does occur you will not get the blame for it. It is a very rare thing for me to end a labor with the forceps on. When the perinæum begins to bulge, I support the handles to see whether the pains are strong enough to end the labor. If so, I remove the forceps. There is such an abuse of this instrument that I sometimes think that Baudelocque was right when he said that the forceps had done more harm than good. It requires great skill and judgment to end a labor with the forceps. A physician from inexperience, or being demoralized by a long and tedious labor, is liable to use undue violence and deliver the head too quickly, or to make a traction in the wrong direction. I have myself torn the perinæum and seen many good physicians do the same. From this experience

I should recommend that, unless their be an excellent reason for contrary action, the forceps be taken off when the head reaches the perinæum. Occasionally one blade will catch over an ear and you cannot get it off; but in the majority of cases it can be removed, and that is the proper thing to do.

PRESERVATION OF BODIES FOR DISSECTION.—O. T. Freer writes from Munich that, in the anatomical department of the University, the material used for dissection seems to keep fresh much longer than he has found to be the case in the medical colleges. He learned from Prof. Rudinger that the injecting fluid used in the preparation of the bodies is a mixture of carbolic acid, glycerine and alcohol, and this method has been in use since 1882. Subjects injected with this mixture will keep fresh from two to six months, according to the quantity of injection used. For preserving bodies three to six months, the solution is composed of glycerine, 40 parts; carbolic acid, crystalized, 11; alcohol, 8. For preserving them two to three months, glycerine, 80 parts; carbolic acid, 17; alcohol, 13. The injection is made into the femoral artery, and the amount used is two to four litres, or quarts, though an ordinary subject will readily contain fifty per cent. more than the larger quantity.—*Chic. Med. Jour. and Ex.*, July. 1884.

CHRONIC NASAL CATARRH.—Dr. M. M. Brown, M.D. of Ithaca, N. Y. (*Med. Summary*) gives the following treatment for chronic nasal catarrh—where hard scabs are formed.

R Acid carbolic, gtts. xv,
Potass permang., grs. v,
Aqua. 3 ij,
Glycerine, q. s. ad., 3 ij M

To be applied to nostrils in the following manner with a camel's hair brush, nightly. Saturate a long camel's hair brush in a sufficient quantity of the fluid, push the brush well into the nostrils after having blown the passages clear of crusts, allow the brush to remain for five minutes in each nostril, or until the preparation can be tasted in the fauces. Repeat this until all signs of disease have disappeared. Constitutional remedies should also be used, such as iodine, iodide of potass, in syrup of ginger, etc. Dyspepsia and mal-assimilation of the ingestæ should be corrected in every case. When there is much discharge of an offensive nature, mingled oftentimes with bloody matter dropping into the fauces after meals and on getting up from bed, I apply the following powder once a day to the fauces and nasal passages with an insufflator:

R Potass permang., grs. x,
Talc 3 j,
Bismuth Subnit., 3 j,
Hydrarg. chlor. corrosiv., grs. ij. M.
Ft. in pulv.

Ten grains of this powder blown upon the diseased surface behind the velum and into the anterior nares every evening works like a charm. Prepare the powder carefully. Still another formula, when the fetor is intense:

R Iodoform,
Calomel,
Bismuth subnit., aa 3 j,
Talc, 3 ij. M.
Ft. in pulv.

I prefer this powder to the first named in nearly all cases. For chronic sore throat I use the following solution:

R Hydrarg chlor. corrosiv., grs. ij,
Alcohol, 3 ij,
Aqua q. s. ad., 3 ij. M.

Apply with camel's hair brush to the enlarged follicles two or three times a week. If smarting is intense mitigate it with glycerine or a little vaseline.

PRURITUS VULVÆ.—Itching of the external genitalia is one of the most prevalent and tormenting conditions with which a woman can be afflicted. Hence, any remedy that will palliate this disorder is gratefully received by both patient and physician.

Dr. C. J. Smith of New York says:—The following formula has, in my hands, given relief when nothing else has been of the slightest benefit:

R Ext. geranii mas. fluid, gtts. xx,
Ext. belladonæ fluid, gtts. iij,
Zinc. sulph., gr. j.
Vaseline, 3. j M.

Sig.—For external application.

If the parts are not much inflamed I usually omit the belladonna. I have prescribed this in many cases, and with few exceptions, it has afforded immediate, and, in some instances, permanent relief. I have found it of value in pruritus ani.—*Medical Advocate*.

STRANGULATED HERNIA.—The *British Medical Journal* gives us the following points on the diagnosis of strangulated hernia. Dr. Englisch, of Vienna, on examining the urine of patients under treatment for strangulated hernia, has ascertained that it always presents albumen in proportion to the duration of the strangulation. If surgical means be not adopted, the albuminuria continues until the death of the patient. The quantity of albumen is not affected either by the date of the hernia, the size of the sac, the frequency of the anterior strangulations, nor by a febrile condition. When there is simple protrusion of the omentum, albumen is absent. Prof. Nothnagel attributes this albuminuria to diminished intravascular pressure resulting from the presence of a strangulated hernia.

—*Kansas City Medical Record*.

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The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

THE PHYSICIANS OF THE FUTURE.

Physicians and Surgeons in the British Isles, we are aware, are averse to specialism. Even those who pre-eminently excel in the treatment of particular classes of diseases, strive, by avoiding the habit of devoting themselves to these single classes, to set an example of a general rather than a limited practice. Despite this tendency, however, we cannot but think that specialism is the feature of the age. As the population increases, the amount of labour and competition proportionately increases. The result is that the law of the division of labour is now carried to its extreme limits. Nor is this law confined by any means to manual labour; intellectual labour comes equally under its operation. In short, specialism in every form is the salient characteristic of the nineteenth century. Grant Allen, in an article in the *Nineteenth Century* some months ago, very wittily pointed this out in an imaginary dialogue in which an Oxford graduate, despairing of fame in a life devoted to Greek, or Latin, or even Hebrew, Chaldee, or Syriac, vowed that he was "going in for the Ostiak dialect of Tungusian." The richness of the joke is only apparent when it is known that the Tungusks are an obscure little tribe of fishermen living on the almost unknown banks of the Yenisei, and that the Ostiak dialect is a corruption of their language by a yet more obscure neighbouring tribe.

In the science and practice of medicine and surgery specialism certainly is a most marked fea-

ture. Should it continue to increase at the same pace as it has done for some years past, it is no uninteresting and certainly no uninteresting task to see where it will eventually land the profession. And indeed, the consideration of this subject is almost a duty. The young practitioner, and especially the student, must look ahead and endeavour to foretell, and to adjust his methods to the profession as it will be, when he hopes to be in its front ranks.

What, in broad outline, has been the history of specialism during the lifetime of the medical man who was "capped," say fifty years ago? The first step in this direction was, probably, the separation of wards in a hospital for distinct diseases. Then followed entire hospitals devoted to a single class of diseases. These gave opportunities for special study, and from these arose the famed specialists of to-day. The effect of this upon the profession at large is, that the class of cases treated by the general practitioner—and by general practitioner we do not refer to those who, as Bacon says, "take all knowledge to be their province," the "physician, surgeon and accoucheur"—will gradually become more and more limited. A patient has ear-ache; he calls in a general practitioner, who prescribes morphine. The effects of the morphine wear off, the ear-ache returns. He then goes to an aurist. The aurist diagnoses catarrh of the middle ear, punctures the membrana tympani, and cures the ear-ache. Any medical man could multiply such instances a hundred fold. And it is instances like this, daily occurring, that will soon teach the public to forsake the "family doctor" and resort to the "eye, ear, throat, lung, and nose doctor." The family doctor will soon be an institution of the past, and his place will be taken by a circle of doctors. Materfamilias will go to her gynecologist; paterfamilias probably to the whole round, according as he imagines it is his liver, or his heart, or his lungs, or his spleen that is affected.

We are by no means treating the subject lightly. But to come to a sober view of the case, and seriously to conjecture, on scientific principles, what will be the character of the physicians of the future. We think we shall express the opinion of the majority of the faculty in the following prophecy:—First, there undoubtedly will be men who by their fame as diagnosticians will be resorted to on the first appearance of any malady. Finding his forte

lies solely in diagnosis, and finding it impossible to be thoroughly *au fait* in other branches, *e. g.*, therapeutics, treatment, posology, etc., in the then enormously wide areas that these will cover (we speak, say of fifty years from now), the diagnostician will hand his patient over to the specialist for the lungs, liver, stomach, nervous system, and so on, just as now the ordinary practitioner hands him over to the oculist or aurist. These will in turn hand him over to the therapist with minute directions as to the effects he wishes to be produced upon the system and the tissues. Still more in the future, probably, there will be classes of diagnosticians and therapists. This is no visionary theory; the germs of such a system exist all around us if we will but recognize them. The same process is obtaining in kindred sciences; for example, in biology there are men who not only devote themselves entirely to one of the two great branches into which it is divided, morphological and functional biology, but go so far as to give themselves up to the study of one minute part of the many divisions into which each of these is broken up—as myological or osteological development, etc.

If then, we are not altogether incorrect in our surmises, the lesson for the student is that if specialism is the tendency of the day, and the all-in-all of the near future, to specialism he must devote himself—with this caution: that no specialism is possible except that which is built upon the broad foundation of a thorough knowledge of anatomy, physiology, chemistry, etc., etc.

THE ANNUAL MEDICAL BANQUETS.

The occurrence of the annual dinners of the graduates, under-graduates and professors of the various medical schools is looked forward to with much interest and pleasure. These occasions are made the opportunity of eliciting the expression of opinion of competent persons on matters connected with education generally, and medical education in particular. That this is recognized by the students themselves is evident from the large number of complimentary tickets issued, and also by the prominence given to those toasts which call forth speeches from eminent educationists and politicians. The banquets this year have been no exception in this respect, and we have been treated

to some very valuable remarks by those best qualified, both from ability and experience to express an opinion. These banquets, according to the custom of the medical dinners for many years, were conducted on strictly temperance principles, and the toasts were drunk in cold water.

The annual banquet of the Toronto School of Medicine was held on the 12th ult., and was well attended. The chair was occupied by Dr. H. Bascom, supported on his right by the Lieut.-Governor of Ontario and Dr. McVicar, and on his left by Mayor Boswell, Prof. Clarke, and others. After justice had been done to the good things provided for the occasion, toast, song and sentiment followed each other in rapid succession, until far into the evening. The Lieut.-Governor in his speech, which was witty and well received, alluded to the obligation which the schools were under to the Hospital, and also gave a short sketch of the history of that institution. Prof. Clarke, of Trinity College, in responding for the "Universities and Colleges," said that in spite of expressions to the contrary there was the best possible feeling between the several universities in Canada. A scheme for the federation of the different universities is now very widely talked about, and he hoped that some such scheme would be effected so that a common standard might be obtained which would ensure degrees of fixed worth. He thought that while a multiplication of colleges was good, a multiplication of universities was an evil. He referred to Dr. Wilson's recent letter in defence of University College, and wished that Dr. Wilson had been more specific in his references to the persons who had made the charges which he combats. He hardly thought that Dr. Wilson placed Trinity University among the number, for Trinity was a non-sectarian university. Prof. Ramsay Wright responded for University College, and Principal Buchan, for Upper Canada College. The "Dominion and Local Legislatures" was responded to by H. E. Clarke, M.P.P. The "Learned Professions," "Graduates and Graduating Class," "General Hospital," "Freshmen," "Ladies," and the "Press," concluded the list of toasts, and a very pleasant evening's entertainment was brought to a close.

The Trinity Medical College banquet took place on the 20th ult., and was very largely attended. The chair was occupied by Mr. P. A. Dewar, sup-

ported on his right by Lieut.-Governor Robinson, Hon. Senator Allan, and Provost Body, and on his left by Hon. Edward Blake, Mayor Boswell, Dr. Widdifield, and others. After dinner was served the sound of the bugle announced the commencement of the toasts. The chairman delivered the opening speech, and in doing so referred to the large increase in the number of Trinity students, which made it the largest medical school in Canada, and also to the honor and success which her graduates had gained in other lands. He made a humorous defence of the students against the charge that they were a noisy, reckless crew, and concluded by proposing the health of "The Queen." "The Governor-General and Lieut.-Governor of Ontario," was responded to by Lieut.-Gov. Robinson. He referred to the large number of medical students about him but said that our vast country would give wide field and scope for their talents. Every profession in Canada had to contribute its portion to the welfare of the State, and he had no doubt the medical fraternity would do its full share thereto. "The Dominion and Provincial Legislatures," was the next toast. Hon. E. Blake, who was cordially received, said he was afraid that in the ranks of the political doctors there were more quacks than among the medical profession. Some people believed that their patient—Canada—was in rather a critical condition. It was said she had been bled too freely; that there were some organic defects in the system which ought even to render an operation necessary. But he was inclined to think that she would stand a good deal of killing. The legislators of this country had serious duties to discharge in welding the various parts of this country into one nation, and creating that unity of feeling essential to make Canada the country she ought to be. To its success was essential a widely diffused education, and a widely diffused public spirit. No man in Canada made a stronger candidate for Parliament than a popular country doctor. No man had more influence, and with the influence came responsibility. The medical profession was indeed a noble one. In the strict line of duty, it was a business of blessing. After referring to the great advances made in recent years in medical science, he concluded by wishing the profession all prosperity. Senator O'Donohoe also responded.

Dr. Widdifield responded on behalf of the "Prov-

incial Legislature." He referred in feeling terms to several of his old friends on the staff of Trinity Medical College, and especially to one who was absent owing to recent family bereavement. He also said that he had had an opportunity of visiting the medical schools of the United States and Europe, and could say that the medical schools of Canada compared favorably with any he had seen. The "Mayor and Corporation" was responded to by Mayor Boswell, who told the students that if they went home singing their songs without shouting he would guarantee they would not be molested by the police. The "Universities and Sister Institutions" was responded to by Chancellor Allan, Drs. Aikins, Barrett and others; "Trinity Medical School," by Dr. Geikie, the Dean; "Toronto General Hospital," by Dr. O'Reilly; and the "College of Physicians and Surgeons, Ontario," by Dr. Morton. The "Learned Professions," "The Ladies," and the "Press," were duly honored. A number of College songs, solos and glees enlivened the proceedings.

ONTARIO MEDICAL ACT AMENDMENTS.

The Committee appointed by the Ontario Medical Council at its last meeting to draft certain amendments to the Ontario Medical Act, met on the 4th ult., and after discussing certain proposed amendments, had an interview with the Attorney-General and other members of the Government, with reference to the same. The Attorney-General promised to give the matter his careful consideration. The proposed amendments were published in the daily press so that we need not reproduce them here. There can be no doubt about the propriety, nay the necessity, for the enactment of some of the clauses. Others, however, are more open to question. The first provides that no College or University shall be entitled to send a representative to the Council unless it has a medical staff of teachers actively engaged in teaching. This clause seems necessary inasmuch as there is a preponderance of college representatives, out of all proportion to the number of territorial members so that in justice to all parties it became necessary either to increase the number of territorial members or lessen the number of College representatives. Another clause which it is most desirable to have placed on the statute book provides,

"That all actions brought against medical practitioners for malpractice must be instituted not later than one year from the date of such so-called malpractice, and also that security for costs in suits for damages be given by plaintiff." It is suggested in regard to the latter that a private examination might be held before a judge of the Superior Court, and if he thought it doubtful that a conviction would be obtained against the defendant he might order the plaintiff to give security for costs. We are somewhat doubtful, however, whether such a provision can be successfully carried through the House, inasmuch as it may be considered class legislation, but it is well worth the effort. The proper payment of medical witnesses in courts of law or equity constitutes another important clause which we hope to see enacted.

One very important clause referring to the internal discipline of members of the College is urgently required. It is useless for the Ontario Medical Council to proceed against unlicensed practitioners and enforce the penalties of the Act, so long as impecunious registered practitioners are permitted to prostitute their high calling by accepting salaries from the ignorant pretenders who infest the country. The following clause, taken from the British Medical Act, giving the Council power to erase or suspend the name of any one who has been "guilty of any infamous or disgraceful conduct in a professional respect," might without any difficulty be passed through the House. There appears to be considerable objection to the proposed clause relating to the annual fees payable to the Council. Many object to the payment of an annual fee of \$5, and also to the commutation life payment of \$20, less the amount already paid in annual assessment dues, claiming that it is an interference with vested rights. The main difficulty appears to arise out of the inconvenience of collecting the small annual fee of \$1 under the present working of the Act. If, therefore, the following clause were added, leaving the annual assessment as at present, the matter would be placed on a more satisfactory footing, viz.: that such fee shall be deemed to be a debt due by the member to the College, and be recoverable with costs of suit in the name of the College of Physicians and Surgeons of Ontario, in the Division Court in the City of Toronto.

EDWARD M. HOOPLE, M.D. L.R.C.P. etc.

Dr. Hoople of Atlanta, Ga., formerly of Toronto, who died on the 3rd of last month of typhoid fever complicated with hemorrhage of the bowels, was a young man of great promise. He graduated with honors in Trinity Medical College in 1883, and after obtaining the above mentioned British qualifications, settled in Atlanta, Ga. We have received a long letter from Dr. G. G. Roy, Prof. of Materia Medica in the Southern Medical College, giving a detailed history of his illness, and speaking in the highest terms of his professional abilities, kindness of heart, and amiability of character. We regret that the letter is too long for the space at our disposal. Dr. H. was rapidly gaining the confidence of the people in his new-found southern home, and had he lived would soon have secured a lucrative practice. His family and friends have our deepest sympathy in their affliction.

GEO. W. NELSON, M.D. C.M.

The subject of this notice was resident surgeon of the Panama Canal Company's Hospital. He came of a family of doctors, being the ninth in direct descent, and the second son of the late Dr. Horace Nelson of Montreal. He graduated with honors in Bishop's Medical College in 1879, taking the final prize. After graduation he practiced a short time in Mount Forest, Ont., and then in Marbleton, Que. His health having given way he removed to a warmer climate, and being offered the appointment in the Canal Company's service he accepted it. He filled the position not only most ably, but also amassed a valuable collection of clinical notes on the fevers of the country; and a series of meteorological observations conducted by him, will throw some valuable light on the influence of atmospheric conditions on yellow fever. They will be published for the benefit of the profession, in the near future. He was a man of genial and kindly nature, frank and manly in his social relations, and much loved and respected. We tender Dr. Wolfred Nelson, and the other members of the family, our warmest sympathy in their sorrow and loss.

EDWARD JENNINGS, M.D.

We regret to announce the death of Dr. Edward

Jennings, of Halifax, N.S., at the age of 68 years. He graduated in 1843, and was probably one of the best known physicians in that city. Although brusque in manner, few men were more kindly disposed or did more charity work than Dr. Jennings. He was coroner for many years, and his position gave him opportunities of doing good which he availed himself of in endeavoring to bring about reforms in the social and sanitary condition of his fellow-citizens. His death will be deeply regretted by a large circle of acquaintances.

GEORGE WILLCOCK, M. D., L.R.C.P., ED.

The sudden and unexpected death of Dr. Willcock of this city, in the prime of active professional life, was a surprise to his many warm friends. He was a man of great promise, and had his life been spared a few years, he would have risen to eminence in his chosen profession. He was greatly beloved and respected, and leaves a wife (a relative of W. W. Ogden, M.D.) and one child to mourn his untimely loss.

MURIATE OF COCAINE.—In our last number we made a short note of this new and valuable anæsthetic. Since then it has been tried extensively in nearly all the cities of the new world, and the medical journals are filled with reports of its use, and the satisfactory nature of the results obtained. Its peculiar properties have been known to the profession for about a year, its use being to diminish sensibility in operations on the larynx. Dr. Koller first demonstrated its anæsthetic properties on the eye at the Ophthalmological Congress in Heidelberg, in September last. Since that time it has been tested by ophthalmologists in Europe and America with the most satisfactory results. Cocaine is an alkaloid obtained from the leaves of the *erythroxylon coca*. The drug is applied by instilling into (or brushing over) the part a four per cent. solution at short intervals until complete insensibility is produced, when the operation may at once be proceeded with. Reports of its use in practice by Drs. Rosebrugh and Reeve of this city will be found in another column.

AS OTHERS SEE US.—Prof. Struthers who visited Canada with the British Science Association, in his opening address in Aberdeen University, stated that he never heard better speaking than at the

dinner of the Canadian Medical Association in Montreal, or more evidence of culture in the profession of any country. He also spoke very highly of our preliminary and professional examinations, and the excellent character of the teaching and examinations of our Universities. In his opinion however, better endowments were required for our scientific chairs. In conclusion he said that upon the whole the medical profession in Canada deserve the best sympathy and support from Great Britain in its efforts to maintain a good standard in the face of the depressing tendencies of the system of the neighbouring States of America.

A MATTER OF OPINION.—We have again been favored with one of those magnificent works of art by John Rogers, 23 Union Square, New York. The following cut gives a faint idea of the design of the artist. It represents two physicians in consultation over a lady patient. One of them is ex-



amining the pulse and apparently explaining his view of the case. The other plainly shows his scorn and contempt for such a gross breach of professional etiquette and is buttoning up his coat and preparing to leave. The work must be seen to be fully appreciated. It would be most suitable as a Christmas or wedding present, or as an ornament in a doctor's office.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.—This Society held its first meeting of the season on Fri-

day, October 31st; the President, Dr. Powell, in the chair. The Secretary's report was read, showing the affairs of the society to be prosperous. It was unanimously decided to hold the regular meetings twice a month during the coming year. The following officers were then elected:—President, Dr. J. A. Grant; Vice-Presidents, Drs. Horsey and S. Wright; Secretary-Treasurer, Dr. Grant, Jr.

At the regular meeting, November 14th, the President delivered the annual address, which will appear in our next issue. At the next meeting the city health and local sanitary matters will be considered, the Board of Health being invited to be present.

BRITISH DIPLOMAS.—Dr. E. M. Hewish (Toronto), has received his Diploma of the Royal College of Surgeons, England.

Drs. Dorland, Davy, Lawton and Stalker (Trin.) have taken the L. R. C. P., Edin., and Dr. W. F. Freeman (Trin.) has taken the triple qualification of the Colleges of Physicians and Surgeons of Edinburgh and Glasgow.

T. S. Covernton, M.D., L.R.C.P., Edin., son of Dr. C. W. Covernton of this city, has recently passed the examination for the Diploma of Sanitary Science in the University of Cambridge. This examination is the most severe of any of the kind in any part of the world.

APPOINTMENTS.—Dr. J. J. Gardner has been appointed Visiting Physician to the General Hospital *vice* Dr. Burland, resigned.

Drs. C. A. Sharpe and D. A. Cameron have been appointed on the assistant staff of the Montreal General Hospital *vice* Drs. Graham and Ferguson, resigned.

Dr. J. E. Jenner has been appointed on the assistant staff of the Toronto General Hospital.

Dr. A. T. Carson has been appointed lecturer on Botany in the Women's Medical College, Toronto.

PERSONAL.—The friends of the Rev. Dr. Johnston of Brownstown, Jamaica, the well-known missionary, will be pleased to learn that he has finished his medical course at Edinburgh, and has returned to the scene of his labors. He was greeted on his return most enthusiastically by his people and congregation. He took the degree of M.D. C.M. in Trinity Medical College, Toronto, and

subsequently obtained the double qualification of L.R.C.P. & S. Edin. We wish him continued success and prosperity in his good work.

THE NEW SPECIFIC FOR RHEUMATISM.—In the *N. Y. Med. Journal* for Nov. 8th, 1884, Dr. Seelye, of Amherst, Mass., gives an analysis of 118 cases of rheumatism treated with the new specific—the oil of gaultheria, or oil of wintergreen. His experience of its use has led him to place great reliance upon it in the treatment of all rheumatoid affections. It may be administered in capsules or combined with salicylate of sodium or in an emulsion of ten minims of the oil to half a drachm each of glycerine and water. Relief was usually obtained within from twelve to twenty-four hours.

PIROTOXIN IN NIGHT-SWEATS.—In the hope of obtaining a remedy that would control the exhausting night-sweats of phthisis, Dr. Cauldwell of St. Joseph's Hospital, New York, has made a series of experiments with several recognized remedies and has arrived at the conclusion that picrotoxin comes nearer the ideal than any other drug. It was prescribed in twenty cases, in seventeen of which the perspirations were either entirely checked or materially diminished. A single full dose $\frac{1}{4}$ of a grain at bed-time was generally sufficient to control the sweating.

HONOR TO WHOM HONOR IS DUE.—We are pleased to announce that Dr. Joseph Workman of this city was elected an honorary member of the Phreniatric Society of Italy in September, 1883; also an honorary member of the British Medico-Psychological Association in July, 1884. We congratulate the worthy gentleman upon the appreciation of his labours by his confrères both at home and abroad.

IMPOTENCE IN THE MALE.—The following is highly recommended by Dr. Hammond, of New York:

R Strychniæ sulph.....gr. i.
Acid phos. dil. 3 i. M.

Sig.—Ten drops to be taken in a teaspoonful of fluid extract of coca before meals.

Dr. H. O. McLatchy, of Wolfville, N.S., has received a silver cup as a special prize for a specimen of apples at the fruit and vegetable show in the Crystal Palace, London, Eng.

SCHOOL HYGIENE.—A most excellent paper on "School Hygiene" was read at the Teachers' Association in the County of Essex, on the 23rd of October, by Dr. Coventry, of Windsor, Ont. It is published in the *Essex Record* for Nov. 7, 1884.

MEDICAL COUNCIL ELECTIONS.—We have been requested to state that Dr. Burritt, the present member for Newcastle and Trent, will not be a candidate for re-election. Having removed from the Territorial Division he is not eligible under the Act.

In Memoriam.

ISABELLA C. FULTON.

Born May 20th, 1844.

Died Oct. 28th, 1884.

In kind and loving remembrance of a devoted wife, and a kind, loving and affectionate Christian mother, these lines are dedicated. Words can but feebly express the many good qualities of head and heart by which her life was so distinguished. The highest welfare and happiness of her husband and family were her constant solicitude and care, and no sacrifice was too great to accomplish her desires in these respects. Her memory will ever live in their affections, and her prayers will be taken up and repeated by those who were taught them so faithfully as soon as they were able to lisp. Her husband has lost a true and devoted wife, and her children have sustained the greatest of all losses—the influence, care, and example of a Christian mother. Her goodness of heart and faithful motherly example, won for her the deepest love and admiration of all who knew her intimately. Many a poor family will sadly miss her kind ministrations during this inclement season. Though not customary to use these columns for obituary notices except for medical men who have distinguished themselves in some way, it seems only a fitting memorial to one who contributed so much to the success of this journal, by the assistance she gave her husband in his labor, to consecrate a small space to her memory.

Books and Pamphlets.

THE POPULAR SCIENCE MONTHLY FOR NOVEMBER, 1884. New York: D. Appleton & Company. Fifty cents a number, \$5 a year.

"The Relations between the Mind and the Nervous System, by Dr. W. A. Hammond, occupies the leading place in the November "Popular Science Monthly." He defines mind as a force developed by gray nerve-tissue, and maintains that this force is generated wherever in the living organism gray nerve-tissue is found, citing many striking cases in support of this view. He denies that either the absolute or the proportionate weight of the brain indicates a definite rank in intelligence. This number contains also Herbert Spencer's replies to recent statements made by Frederick Harrison as to the "Origin of the Synthetic Philosophy." Two thoughtful addresses delivered at the recent meeting of the American Association are given in full—"Pending Problems of Astronomy," by Professor C. A. Young, and "What is Electricity?" by Professor John Trowbridge. "The Future of the Negro in the South" is treated in a witty but convincing manner by J. B. Craighead, who evidently knows the Southern negro well. Among other interesting articles may be mentioned "Chemistry of Cookery," "The Oil-Supply of the World," "Sketch of Professor James Hall." The number is a promising opening for Volume XXVI.

THE PRINCIPLES AND PRACTICE OF MEDICINE BY N. S. DAVIS, M.D., Chicago, Ill. Chicago: Jansen, McClurg & Co. Toronto: Williamson & Co.

This work is not a compilation, but an embodiment of the observations, thoughts, and experiences of the author during nearly fifty years of active medical practice. The matter is presented in the form of lectures delivered by him during his many years of teaching. The features which especially commend the work to the practitioner and student, are the fulness with which the clinical history of the various diseases is given, and the explicit and detailed description of the methods of treatment which have been found most effective. The author's adoption of the metric system of weights and measures is worthy of notice and commendation. Although this system has been advocated by leading scientific and medical societies, it has come into use only to a limited extent. To assist in

effecting this change, Dr. Davis has used the metric system throughout the work, giving however, in brackets, the equivalents in apothecaries' measure. The author is well known throughout the United States and Canada as one of the ablest and most original thinkers in the profession, who has won a deservedly high reputation as a lecturer upon practical medicine; and the profession is to be congratulated upon having in a permanent form the rich results of his busy professional life.

TEXT-BOOK OF PRACTICAL MEDICINE, FOR THE USE OF STUDENTS AND PRACTITIONERS OF MEDICINE BY ALFRED L. LOOMIS, M.D. LL.D. with two hundred and eleven illustrations. New York: W. Wood & Co. Toronto: Hart & Co.

There is probably no clinical teacher of the present day better qualified to write a work on the practice of medicine. Many of his pupils will be glad to have a copy of his work for reference, and the general profession cannot fail to appreciate a work of such utility as the volume before us. The work is essentially an elaboration of the lectures given during the past eighteen years in the medical department of the University of New York. The author has done his work well, and has produced a book of which he may justly be proud. We regard it as second to none on the practice of medicine.

MALARIA AND MALARIAL DISEASES. By George M. Steinberg, M.D., F.R.M.S. William Wood & Co., New York.

This is a very exhaustive, pleasantly written and well arranged work, in ten chapters: I. Mode of infection or intoxication. II. Conditions governing the evolution and dissemination of malaria. III. General effects of malaria. IV. Speculations and researches relating to its nature. V. Antidotes to malarial poisoning. VI. Prophylaxis. VII. Geographical distribution. Part Second. VIII. Malarial intermittent fever. IX. Continued malarial fever. X. Hæmorrhagic malarial fever. In these chapters the literature of the subject generally as well as the recorded experience of recent foreign writers is freely given, the whole forming a work of great practical value to general practitioners.

DISEASES OF WOMEN AND UTERINE THERAPEUTICS by H. MacNaughton Jones, M.D. New York: D. Appleton & Co.

MEDICAL RHYMES, BY HUGO ERICHSEN, M.D., with introduction by Prof. Willis P. King, M.D., Sedalia, Mo. St. Louis: Chambers & Co.

This work contains a collection of rhymes ancient and modern; grave and mirthful; rhymes anatomical, therapeutical and surgical, in short all sorts of rhymes to interest, amuse and edify all sorts of followers of Æsculapius, so says the author in his preface, and a casual examination of its contents would seem to bear out the statement. Some of the verses are very witty and humorous; some of a very high order of merit, and some very indifferent. On the whole the work is worthy of perusal, and will interest and amuse the busy doctor in his leisure hours.

INDEX-CATALOGUE OF LIBRARY OF SURGEON-GENERAL'S OFFICE, UNITED STATES ARMY, Vol. v. Flaccus-Hearth: Washington Government Printing Office.

This extensive volume is but one of a series of which the reader may form some estimate by observing that it embraces only those subjects in alphabetical order between the words *Flaccus* and *Hearth*. The labor in preparing this index must be something enormous, but when completed it will be the most extensive work of the kind in the world.

LOCK-JAW OF INFANTS by J. F. Hartigan, M.D. New York: Bermingham Company.

Births, Marriages and Deaths.

On the 29th of October, Louis E. Day, M.D., to Jennie McAlpine, second daughter of John Harstone, Esq., merchant, Harwood, Ont.

On the 28th of October, Chas. W. Alden, M.D., of Hampton, N.B., to Margaret Hamilton, youngest daughter of Wm. Thompson, Esq., and neice of the late Hon. M. H. Foley.

In Toronto, on the 18th ult., George Willcock, M.D., L.R.C.P., Edin., aged 33 years.

In Halifax, on the 14th ult., Edward Jennings, M.D., in the 68th year of his age.

At Santa Barbara, California, on the 2nd ult., George W. Nelson, M.D., C.M., aged 26 years.

*** The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

THE CANADA LANCET.

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Original Communications.

ADDRESS ON MEDICINE AT THE ANNUAL MEETING OF THE MEDICO-CHIRURGICAL SOCIETY, OTTAWA.

BY J. A. GRANT, M.D., F.R.C.P., LOND.

Consulting Physician to the County of Carleton General Hospital;
also to the General Hospital, Ottawa.

GENTLEMEN,—Thirty years have just passed since I had the pleasure and good fortune to become a member of the profession in this city. Our number was then small; we had neither telegraphs, telephones, nor electric lights, all of which have since been added, and in the immediate domain of the profession, vast strides have been made in every department, indicating alike the march of scientific advance in the field of labor in which we are called to duty. Let me thank you for the honor you have now conferred, in electing me President, and my son, Secretary-Treasurer of the Medico-Chirurgical Society for the ensuing year. I have on various occasions experienced your thoughtful consideration, and to be again honored, after so many years spent with you, is an evidence of your continued confidence, at a time when the termination of my professional career cannot be very far off, under ordinary circumstances. The life so far has been an exceedingly happy one, and my earnest desire has been to promote a mutual regard and self respect amongst our brethren, and thus unite our efforts in the discharge of the varied responsibilities entrusted to our care. The success of the medical profession depends greatly on close and continued observation, in order to eliminate the practical issues of bed-side experience, which after all is the light and lamp which cheers us on in our work. The efforts of a single individual can accomplish but little, compared with the combined exertions of various laborers in the same line of research. Each medical society should be a centre of intellectual co-operation, comparing, strengthen-

ing and fortifying, each new idea each ray of light, which may be thrown on any obscure point, until it intensifies and grows, so as to be worthy of the recognition of science. No man is perfect, and each day proves the vast importance of ascertaining carefully our facts, their mutual relations, and the deductions to be drawn therefrom. During this coming year let me invite your hearty co-operation and assistance. Our country is comparatively new, and our scientific societies and institutions, are gradually budding into practical usefulness. Canada and the Canadian medical profession are now better known in transatlantic centres of learning than at any previous period in our history, and all we desire is an honorable record. Each medical society is a parent cell of the intellectual medical structure, as a whole, of our Dominion, the reflex influence of which, for good, will greatly depend on united intellectual co-operation. Thus we will attain the esteem and good will of those at home and abroad and strengthen the ties which unite us together as a working body, working to make "our lives sublime," by the relief of suffering humanity. The march of progress in medical science we have evidence of in every department of the profession, and on this present occasion I shall invite your attention to a few lines of thought, now being thoroughly traversed, particularly in medicine, physiology, pathology, and therapeutics. The relationship of disease to minute forms of life is attracting the most careful enquiry in the field of microscopic research. Until recently, large bodies, rather than small, have engaged the chief share of attention. To-day however, we note that the small things of creation, such as fungi, blights, mildews, moulds and bacteria, so intimately associated with life and death, have aroused more than an ordinary degree of interest. By the aid of the microscope we can demonstrate those minute forms, rod-shaped, spiral, globular, filamentous, and termed bacteria, classed as vegetable parasites and capable of promoting general systemic disturbance. Earth, air and water contain these minute forms, and their mission is so directed as to manipulate the elements of disintegration and decay, and institute a purifying process. Bacteria may prove harmless or otherwise, in accordance with their peculiarity of action. In the performance of the various functions of life, thousands of these bodies enter the system, largely

through the lungs, and gradually make their way into the fluids of the lymphatics and blood-vessels. Should they find a basis of operation congenial, they will grow and multiply rapidly, and develop bacterial disease. The albuminoids and carbohydrates afford grand centres for their operation. They are active factors in putrid decomposition; transform sugar into lactic acid; lactic acid into butyric acid; alcohol into acetic acid, and sugar into a slimy gum. When these products of their activity find entrance into the human system, specific bacterial disease is produced. Then it becomes a question which shall prevail, the tissue cells of the system, which by their inherent power may overcome bacterial influence, or the bacteria overpower the system and induce death. They have a congenial soil when in active operation. The bacillus of splenic fever and consumption, and the bacillus anthracis, have their own characteristics, and may by cultivation part with their dangerous power, as far as promotion of disease is concerned.

Pasteur has demonstrated beyond doubt, that by introducing a minute quantity of diseased structure charged with its specific bacteria, into the tissue of healthy animals, that the identical disease is reproduced. What is still more interesting is the fact, that virulent and poisonous bacilli, can by cultivation, be so changed, as to part with their poisonous power. Here comes in the vaccinating principle of the bacillus; its prophylactic action against invasion of the original disease. We constantly observe in practice, how an attack of scarlet fever, measles, etc., almost precludes the possibility of a second such occurrence. The precise power is difficult to define, and parasitic action may be the chief factor in the remarkable protection. We know well what vaccination has accomplished, and the same principle may yet be so arranged as to place under control many zymotic diseases which still scourge the human family. The question of the precise relationship of organisms to the processes of putrefaction and fermentation, is beset by diversified views; followers of Pasteur's germ theory, holding that bacteria are invariably the initiators of these chemical changes, while others contend that putrefaction and fermentation may take place, independent of these low forms of life. The question of cause and effect, as associated with bacteria, is an interesting problem, and now engaging the

attention of master minds, particularly with reference to the cholera microbe, and the bacillus of tubercle, and let us hope that the result will be both practical and useful, as far as the arrest of disease is concerned. While on the subject of the cholera microbe let me remark, that judging from present indications, cholera is most assuredly gradually moving onward in the course previously taken in 1832 and 1854. In Paris the daily death-rate is quite alarming. The present is the time for activity in carrying out sanitary precautions, so as to be prepared for the advent of spring. Through steam, commercial communication has rapidly increased, and centres of trade thus placed in close relationship, hence the necessity for prompt action. Sanitary rules and regulations are of little service, unless carried into operation. Prevention is a powerful factor, and let our efforts be so directed as to guard the best interest of our people. In this brief introductory I find the subjects so closely interwoven, that with difficulty can the line of thought be isolated. Physiology and pathology have so much in common that they never can be separated, because as sciences they have the same organs and the same functions, under normal or abnormal conditions. It is important that the normal or abnormal condition of an organ should be studied, on the principles of a mutual intercourse. Functional activity and organic change are co-operating powers closely interwoven, which must be noted carefully, in the broadest sense, as progressive evolution in tissue occupies the place of the once healthy organ. Thus comes in the important application of physiological discovery, as an additional prospect for the relief of diseased structure. Lymphatics and leucocytes are points at present possessing more than an ordinary degree of interest, as to the precise part they play in the structure and functions of the system. Blood and lymph are the chief juices of the body, and on that account the purity or impurity, the normality or abnormality of either, directs, controls and determines the powers of the system in structural development, as well as decay. According to Zeigler, the lymph is merely the liquid transuded from the blood vessels, together with certain products of tissue metabolism, and certain matters taken up by the lacteals from the outside. The sources of lymph being so diversified, it is not surprising that occasional morbid changes in its composition

should take place. Until recently the mediastinal and mesenteric glands were the chief source of attention in this important department of absorbing power. In this field of labor Dr. Philipson and Professor Redfern have certainly rendered most valuable service. The lacteals and lymphatics are constantly occupied in supplying the blood with fresh material, from two great sources of life, air and food, and thus become supplementary to the general vascular system. It is a settled point that in the extremities, the deep and superficial lymphatics communicate only in the glands, and that the pleura, peritoneum and pericardium, are not closed cavities, but immense lymph sacs, communicating with lymphatic capillaries, by means of stomata. Thus we observe the existence of an additional lever as to the absorption of abnormal products, and a system of escape, into the general lymphatic channels. Hoggan (*Journal of Anatomy and Physiology*) has defined a newly observed disease of the lymphatics, viz., multiple lymphatic nævi of the skin, thought to be quite as common as venous nævi, which it frequently complicates, and is also the initial or predisposing stage of other diseases, such as lymphatic varix of the larger vessels, and also of elephantiasis. Dilatation of lymphatics is most common in warm and moist climates, and to Manson we owe the interesting discovery, that a prolific cause of dilatation in these vessels, is owing to plugging by the aborted ova of the "*Filaria sanguinis hominis*." The causes and processes of disease, now occupy more attention than anatomical results; and the experimental production of disease is slowly working its way, and will doubtless lead to very important data. How strangely blood, the great vital fluid is disposed, and its abounding leucocytes. What their function, or what part they play in the economy, is yet unsolved. From the fact of being in the blood so abundantly, we would suppose an intimate relationship, with life-giving processes of action. On the other hand however, we note numerous masses of leucocyte-shaped cells, in the vessels surrounding, rapidly developing sarcomatous tumors. Are there leucocytes of life, and leucocytes of death? Long since the blood was considered as the source of cancer, and certainly the close affinity of leucocytic action becomes an exceedingly interesting physiological problem. Another constituent of blood intimately associated with structural development, and at

times ejected as abnormal material, is albumen. Clinically its importance has undergone considerable modification, as far as constantly being a factor of organic disease is concerned. In truth it is known that we may have kidney disease, minus albumen, and *vice versa*. Johnson, of King's College, London, affirms that "the smallest trace of albumen in the urine is always pathological." It is "the frequently recurring and persistent albuminuria which is found to be sooner or later associated with serious structural degeneration of the kidney." By far the most numerous cases of albuminuria, are those occurring in persons supposed to be healthy, but who at some previous period, have had an attack of acute renal trouble. Quasi health with latent disease, frequently follows such attacks, and cannot be too cautiously guarded. It is interesting to have in view the fact that while urine voided before breakfast, and after a night's rest, is free from albumen, yet, after food and exercise, it may become abundant. Renal or non-renal albuminuria, is the question. It is known that frequently, both before and after menstruation, for a few days at least, the urine may contain a small quantity of albumen. Various trivial causes are cited as producing albumen in the urine, and amongst others, indiscretions of youth. The absence of constitutional evidences of renal disease, with urine normal in every other particular, excepting albumen, would point to a local origin, non-renal in character. Albumen under any circumstance cannot be too critically examined. In Canada my observation leads me to the belief, that the most prolific source of kidney-trouble, is alcohol; not alcohol in large quantities, but the quiet, and regular use, in the daily round of life. Many escape this disease, thanks to the power of their kidneys, but on the other hand, not a few come to grief. Night micturition is an early indication, and alcohol has actually been found in the urine, having escaped thus, from the over charged system. Albumen is, then, only sometimes present. Too much stress cannot be placed on the power which alcohol exercises on the system, even in moderate form, towards the development of albuminuria. The study of diseased manifestations, naturally leads to the means at our disposal, the therapeutic lever, and how to be applied. The only true method by which practical results can be achieved, is by experiments on the lower animals;

statistical observation of the results of treatment, and lastly individual observation. Could our local society not be constituted a collective investigation committee? At present each member works in a practice circle of his own. Could the various circles be united, as to practical results, much valuable information would be brought together. What can possibly be more diverse than the treatment of disease? In many diseases, the very multiplicity of remedies recommended, by the most advanced authors, for the relief of the same, tend to throw doubt on therapeutic action. Cholera, diphtheria and typhoid fever. How varied the recommendations for this tripod of disease! The uncertainty of medicine is well known, and still how frequently we note its practical utility. The non-reliability of the materia medica is daily decreasing, and how? by the careful and patient study of philosophical and physiological facts. Thus the reactions in human chemistry are worked out on plain and simple principles, providing nature's laboratory is not overburdened by the endless variety of pseudo-medical nostrums, placed before the public in popular form. It is somewhat remarkable how few of the many therapeutic agents upon which we pin the greatest reliance, have been the result of direct experiment, or scientific enquiry. We recognise the power of quinine in intermittent fevers, and debilitated states of the system generally, and yet how defective is our knowledge as to the precise action of this material on the system. Again, we all note the power and influence of bromide and iodide of potassium, and yet their employment has not been the result of scientific induction, as the outcome of either physiological or pathological enquiry. In this line of thought much doubtless has been accomplished, but there is still much to learn. In Canada fortunately there is no legislative enactment against "vivi-section," one of the greatest possible blessings of humanity, as a means of carrying out scientific research. In the development of Canadian history and interests, we hope to see more time and means devoted to original investigation. Discoveries, through scientific enquiry, in the direction of the human system, would be exceedingly gratifying records, in the march of progress in our new country. We have an intellectual activity of no low order, and with our native growth, schooled at home and abroad, in the most progressive centres of Great Britain and Europe,

we naturally look for, and anticipate competitive scientific enquiry, into the complex operations of a system which has thus far taxed the most acute observation in solving the problems of life. "Not what I have, but what I can do, is my kingdom," says Thomas Carlyle. Fortune may not be our lot; but an honest living we shall have, and with the trust placed in our hands, let us so discharge our duties as to gain the esteem and respect of our fellow-men.

A RECORD OF CASES TREATED IN THE ROYAL INFIRMARY, FROM NOV. 1883 TO MAY, 1884.*

BY ANGUS MACDONALD, M.D., F.R.C.S.E.
Physician to the Infirmary.

FIBROID TUMORS OF THE UTERUS.

A. N. æt. 36, unmarried, was admitted Nov. 5, 1883, complaining of a swelling in her abdomen. Patient has always enjoyed good health till three years ago, when she felt a severe pain in her back which lasted only three days. Twelve months before admission the same kind of pain returned and since then it has been constant. The pain induced her to go to the doctor who told her there was something wrong with her inside, and advised her to go to the hospital.

Condition on admission—Abdomen distended to about the size of a seven or eight months' pregnancy, but somewhat irregularly, the long end of the oval being oblique upwards from left to right, from the middle of Poupart's ligament on the left side to the top of the last rib on the right side. Tumour is perfectly moveable. Percussion is uniformly dull anteriorly, resonant on both sides, especially on the left. On the right the tumour feels solid, on the left obscure fluctuation is present. In front a soft flat cyst containing fluid can be distinctly felt and it is freely moveable over surface of solid mass behind. On auscultation an impulse is communicated to the ear from all points of the surface of the tumour. On the lower aspect anteriorly a distinct bruit is audible synchronous with heart's first sound. *Per vaginam*—Hymen persistent, pelvis empty, and the vaginal portion of the cervix is represented by a button-like nodule of firm tissue. From this nodule the thinned elongated cervix can be felt extending up-

* Read before the Obstetrical Society, Edinburgh, June, 1884.

wards to the tumour, a distance measured by the sound of between two and three inches. Nov. 23, 1883, Dr. Macdonald opened the abdomen; there were no adhesions whatever. Before the tumour could be removed the incision had to be extended gradually from the symphysis pubis to $1\frac{1}{2}$ -2 inches above the umbilicus. Both ovaries were high up and placed the left anteriorly and the right posteriorly on the tumour. There was a marked twist from left to right forwards; the amount of rotation was quite a quarter of a circle. The neck was elongated and formed a fairly good pedicle. This was embraced by Tait's clamp and secured. The tumour was now cut off about an inch above the clamp. There was very free hemorrhage from the tumour during the operation. The end of the stump did not bleed at all. A further portion of the stump was removed by scissors. The abdominal wound was now secured by thirteen deep and numerous superficial sutures. A quantity of salicylic wool was placed over the wound, a bandage applied and the patient put to bed, and attended to in the usual manner. The whole operation took sixty minutes, and the tumour weighed ten pounds. The patient made an uninterrupted recovery; the highest temperature registered during the convalescence was 99.4 which occurred at 11 a.m. on Nov. 24; pulse averaged 65. Over the stump a little powdered iodoform was sprinkled. No opium was administered. The bowels were moved with castor oil for the first time on 1st December. The deep stitches were removed on the 9th day when complete union by first intention was found throughout. The superficial stitches were taken out on the eleventh day. The clamp separated on Dec. 16th, 1883. January 24, 1884, wound quite healed. The end of the vagina could not be reached; patient discharged.

Remarks—The operation in this case was necessitated by the pain occasioned by the rapid growth of the tumour. There was no trouble from bleeding. The medical attendant who sent the patient reported that the tumour appeared to him to double its size in the course of two months. The bulk of the tumour was made up of degeneration of the anterior wall of the uterus, the body of the organ being round its posterior surface. The marked twist in the tumour is of importance in its bearing upon the treatment of removal of the ovaries for the purpose of arresting the growth of

fibroid tumours. Whilst the left ovary could have been easily removed it would have been completely impossible to reach the right. Before proceeding to operate we had made out clearly that the tumour was clear of the pelvis and had an elongated cervix, two points of the greatest importance in facilitating the operation. The loss of time which occurred in sewing up the abdominal wound arose from the efforts made to secure as completely as possible the lower angle of the wound below the pedicle. In attempting to do this the needle broke and led to considerable delay.

CASE II.—M. B. æt. 54, admitted Feb. 21, 1884, complaining of a swelling in her abdomen and of pain in the swelling. Patient first noticed a lump in her abdomen eight years ago, since that time the lump has gradually increased in size, and during the three weeks previous to her admission it has rapidly grown much larger and feels harder and more pain is present. Patient also states that for two or three weeks before admission she has passed less water than previously, and there has been a disagreeable pain in her back.

Condition on admission—Abdomen is occupied by a large tumour distended to the size of full-term pregnancy. Tumour is hard, moveable, rounded, smooth and oval in shape. Friction is heard anteriorly, soft bruit is audible, synchronous with first sound immediately above pubis in mesial line. Measurement round most prominent part ($3\frac{1}{2}$ inches below umbilicus) = $47\frac{1}{2}$ inches. From right ant. sup. spine of ilium to umbilicus $8\frac{3}{4}$ inches, from left ditto 9 inches. From umbilicus to pubis 9 inches, from umbilicus to ensiform cartilage 9 inches. All over surface of tumour percussion is dull, flanks clear, also clear between ensiform cartilage and upper border of tumour. Vagina rather narrow and elongated, cervix can be felt with extreme difficulty at its upper part, at a level with the upper edge of the symphysis; no part of the tumour can be felt per vaginam, but only one finger can be passed. Sound enters upwards and towards right side, three inches. Urine passed in 24 hours was 24 oz., containing albumen, blood, pus, renal epithelium and blood casts. Patient was put on milk diet, the quantity of urine increased to 50 oz. during the 24 hours, and the week before she was operated on only a trace of blood and albumen could be detected. On the 4th of April Dr. Macdonald performed laparotomy.

The peritoneum was speedily reached ; on passing the hand round the tumour it was found to be free from adhesions. The uterine tumour had so developed as to bring the left ovary forwards and upwards as high as the umbilicus, thereby producing great tension on the left broad ligament. The incision was gradually increased by one-quarter inch at a time, upwards, until the tumour could be pushed through. It was then found that the tumour had a very short pedicle ; round this was passed a Tait's clamp, which was securely tightened. The tumour was now cut off, about an inch above the clamp ; the hemorrhage was found to be completely arrested by the clamp. The edges of the incision were now brought together by deep and superficial stitches. The superfluous tissue of the pedicle was cut off by scissors and the stump dressed by being freely dusted over by a mixture of equal parts of bismuth and iodoform. The rest of the wound was covered by a layer of protective lint. The woman was then put to bed and had a brandy enema administered. The patient made an excellent recovery. The highest temperature reached was 99° F. She passed wind on the third day, and the bowels were moved on the eighth day after castor oil had been given. The deep stitches were removed on the seventh day, the clamp on the 30th of April. The tumour weighed eight pounds.

Remarks.—In this case also the operation was required on account of the bulk and rapid growth of the tumour. It was found to be developed in the posterior uterine wall, the body of the uterus being stretched over its anterior surface. In this case also, removal of the right ovary which lay behind the tumour low down would have been impossible. There were several considerable cavities developed in this tumour, indicating its tendency to fibro-cystic changes. It is also to be noted that the pressure of the tumour appeared to have caused the renal disturbance noted on admission. At any rate when the patient came in there was scanty urine containing blood, casts and albumen. Rest and appropriate treatment speedily rendered the urine both plentiful and healthy. The pedicle in this case was exceedingly short, and as the patient's abdominal walls were very thickly covered with adipose tissue, the clamp sunk deeply into it, and on the left and right side caused a certain amount of ulceration, but on the removal of the clamp

these symptoms rapidly improved. The difficulties connected with the external method makes us sigh for a valuable internal method in this operation ; but the risks of bleeding and of infection are so great that I have not seen it advisable to attempt the internal method ably practised by Schroeder.

CASE III.—M. A. B. æt. 51, admitted January 9, 1884, complaining of enlargement of the abdomen. Patient has menstruated during the last seven years, but her abdomen has been gradually increasing in size. Appears in good health apart from the inconvenience of the tumour.

Condition on admission.—The abdomen is occupied by a more or less rounded, moveable, resistant, hard tumor. Abdomen widest girth measures 39½ inches. Percussion absolutely dull up to 1½ inches below umbilicus, in both flanks note clear. Auscultation gives negative results.

Examination per Vaginem.—The posterior part of the pelvis at its upper end, and a great part of the inlet is occupied by a large tumour, soft anteriorly, hard posteriorly. Arching in a semilunar manner in front of the anterior part of the tumour is a thin, valve-like tissue, which seems to be the thinned anterior lip of the cervix. Using this as a guide, the sound passes up and towards the right 3½ inches. This case admitted of no surgical treatment, more especially as there was no hemorrhage to complain of, and she was dismissed on 24th Jan., 1884, in *statu quo*.

CASE IV.—J. D., æt 43, admitted Feb. 15, 1884, complaining of a tumour in her abdomen. Patient first noticed the tumour four years ago; it has grown slowly and has not been uneasy lately. Menstruation was profuse, but is not so much now as it was nine months ago.

Condition on admission.—The lower part of the abdomen is projected by a tumour of uneven outline, which extends as high as the umbilicus. It is firm, not tender, and freely moveable. On the lower parts of the tumour a bruit synchronous with the heart sound is audible. The girth round the most projecting part of the tumour is 34 inches. Vaginal examination reveals a rounded tumour occupying the posterior part of the inlet continuous with the tumour in the abdomen and moving with it. In front of the os there is also projecting into the anterior part of the pelvis a rounded mass similarly related to the tumour. Sound en-

ters upwards and forwards barely 3 inches without pain. The patient is rather anæmic. She was ordered ergotine suppositories and a chalybeate tonic, and after a rest in the hospital was dismissed on March 23, 1884, as an unsuitable case for operative interference.

CASE V.—M., æt. 48, was admitted on April 9, 1884, complaining of a continual sanguineous discharge and pain in her back. Her illness dates from a miscarriage she had 7 years ago. Patient has had six children and two miscarriages.

Condition on admission.—Patient is very anæmic looking; a systolic murmur is present in all the cardiac areas. Abdomen occupied inferiorly by a rounded, moveable, almost fluctuating tumour, which extends 5 inches above the upper edge of symphysis pubis. The tumour is more developed toward the left than toward the right, although on the whole it is centrally placed. A bruit is heard immediately above the symphysis. Per vaginam the cervix is reached with some difficulty. It is considerably undone, the lower os being traversable to the examining finger which passes in $1\frac{1}{2}$ inches, cervix passes right into tumour which is moveable. No part of the tumour is contained in the pelvis. April 23, patient left hospital owing to domestic affliction.

Observations.—The foregoing cases differed considerably in symptoms and conditions. In case 3 there was no hemorrhage, but the patient applied for relief on account of the bulk of the tumour. There was, however, no evidence to show that the mass was growing fast, and the absence of bruit indicated no great vascularity in the tumour. The difficulty and the risks of removal, when the cervix was undone, and the tumour found to grow so deeply between the layers of the broad ligament, appeared to me so great that I declined to interfere by operation, and accordingly the patient left. I have not heard from her since. Indeed such cases present insuperable difficulties to removal, partly because there is nothing from which to make a pedicle, and partly on account of the enormous adhesions which are found round the mass when the broad ligament is opened up and the downward and outward growth of the tumour occurs. The same remarks apply to cases 4 and 5, only that in regard to them the bleeding was an urgent symptom. But in case four the hemorrhage though still pre-

sent, appeared for several months past to be steadily diminishing; accordingly, I contented myself with recommending ergotine and iron, in the hope that the patient's strength might be kept up until the menopause was fully established, when there is every reason to expect the tumour would shrink and give little further trouble. But case five presented so much distressing bleeding that operation was seriously contemplated. The case did not present a good one for hysterectomy as though there was no pelvic adhesion and no considerable opening out of the broad ligament, the length of the cervix was so encroached upon as to render it all but impossible to get such a pedicle as a clamp could secure. Accordingly I had made up my mind to try the effect of the removal of the ovaries in the hope of inducing a premature arrest of menstruation, and thus removing the most pressing symptom, viz: dangerous flooding. The sudden illness of a daughter of the patient led her to leave the hospital unexpectedly. She was to return if the bleeding continued to be serious, meanwhile she was to employ ergotine and quinine pills. She has not as yet applied for readmission.

ON RAILWAY SPINE.*

BY J. CAMPBELL, M.D. L.R.C.P., ED., SEAFORTH, ONT.

The ever-interesting and ever-important subject of what now generally goes by the name of "Railway Spine" has, during the last year, been attracting renewed interest. This has been owing in a great measure to the publication of Page's work "On the Injuries of the Spine and Spinal Cord." Mr. Page has been for a number of years a surgeon to one of the greatest railway corporations in England, and, therefore, has had a very extended experience of all possible railway injuries, and particularly of cases of so called "railway spine." He contends that cases of what are commonly called concussion of the spine do not exist, except in the imagination of the surgeon making the diagnosis. By "concussion," he means the cord receiving an injury of such a nature as to give rise to pronounced symptoms, without, at the same time, the vertebræ, ligaments or membranes receiving any hurt. It is well known that Mr. Erichsen has been a strenuous advocate of the theory that the great majority of cases of railway injuries having for their symptoms

*Read before the Canada Medical Association, Aug., 1884

spinal symptoms are due to concussion of the spinal cord. The first one hundred pages of Mr. Page's book are taken up with combating this view of Erichsen, and it appears to me that Mr. Page's attempt has been successful. He at least conclusively shows that the vast majority of cases of concussion of the spine are nothing more nor less than cases where the lumbar muscles or the ligaments of the spine have been sprained or ruptured. Erichsen contends that many cases of "concussion of the spine" received in railway accidents never recover, while Page, on the other hand, maintains that these so-called cases of "spinal concussion" always do recover. While representing the reaction, Mr. Page's recent work certainly favors an undue belief in the certainty of recovery in cases of this sort. Erb presents the matter more fairly than either of these writers. Accidents which occur in railway collisions, as other accidents, may lead to a long train of nervous symptoms, and when death has resulted, a post-mortem examination may show little apparent cause for the fatal result. In the greater number of these cases the pathology is a riddle, which, for its satisfactory solution, will need a great deal of experiment and careful and extensive post-mortem investigation. The great trouble in coming to an opinion as to the nature and causes of a train of nervous symptoms following a railway injury is not whether we have to do with a functional or organic change but whether we have to do with an actual or feigned train of symptoms. Usually the patient's symptoms are of such a nature that the physician can come to a conclusion without much trouble; but when he has to do with an intelligent and unscrupulous man, who expects a large sum from a railway company, the case is one of extreme difficulty. In many of these cases it is quite impossible to come to a certain diagnosis. In the words of a recent writer, "the needed clinical work, it seems to us, in the study of 'railway spine,' is the determination of clearly defined types of the disease and the investigation of the varieties from this type and the certain relation of objective symptoms to the disease." That serious and even fatal effects may arise from changes in the cord where it has not received any direct injury has been abundantly proved. In the current number of *Brain*, there is a very instructive case reported by Dr. Edmonds of a soldier who was struck in the

back with a bullet. The bullet entered the back two or three inches from the spine, and the surgeon who first attended him considered that the spine was severely injured because the patient had lost complete control over both lower extremities. Patient had paralysis of the bladder and rectum also. There was cystitis and a bed sore over the sacrum before death, which occurred five months after the injury. At the autopsy, there was no fracture or indication of fracture or dislocation of the vertebræ to be found. The corda vertebralis was intact. The cord was seen to be much atrophied and softened about the level of the wound. On hardening the cord in Müller's fluid, it was seen that there was universal myelitis and softening for about two inches opposite the wound; this gradually passing below into sclerosis of the lateral and anterior pyramidal tracts and above into sclerosis of the posterior median columns. There was no indication of hemorrhage, either external to or into the substance of the cord. Its surface was uninjured. This was undoubtedly a case of pure "spinal concussion." The immediate paraplegia following the injury could not have been due to any other cause. The case is then one of very great importance, as it proves most conclusively that we can have, from a severe shock, sufficient changes brought about in the spinal cord to bring about death, and that these changes are, in the first place, nothing more nor less than "concussion of the spine."

Very recently the opinion appears to be gaining ground that we may have a *tabes dorsalis* arise from peripheral causes; that in fact, an ulcer in the foot may be *fons et origo mali* of this formidable disease. The origin of the disease in such a case is explained by first a peripheral neuritis gradually extending along the course of the nerves until it reaches the posterior roots, and there a similar process gives rise to a subsequent sclerosis of the posterior columns.

EXTENSIVE RUPTURE OF THE URETHRA WITH SATISFACTORY RESULTS.

BY CLARKSON FREEMAN, M.D., MEILTON, ONT.

On the 21st of February, 1884, W. R., æt. 29, farmer, fell from the top of an ice house, a distance of over ten feet, astride the edge of an inch board sleigh box. There was no abrasion of the skin, but

blood came freely from the urethral canal at the time of the accident, and oozed continuously for ten days. He was unable to urinate, and after several ineffectual attempts to introduce a No. 10 catheter I succeeded with a No. 5 gum elastic one, which remained nine days, and was replaced by numbers 6, 7, 8, 9, 10, 11 and 12 consecutively, at intervals of, on an average, seven days, according to the degree of irritation, or the presence or absence of vesical tenesmus. The rupture was nearly three inches in extent on the under surface of the urethra, between the scrotum and the prostate gland. The patient was kept constantly in the recumbent position, with his legs flexed, in consequence of his testicles being painfully swollen and extensive tumefaction of the perineum with ecchymosis from the anus to the prepuce of the penis, which remained for weeks. He had high fever with chills for some days, resulting from the formation of an extensive perineal abscess, which I opened on the 8th of March, to the great relief of the patient. The matter was copious and characterized by a most abominable stench. Under the use of disinfectants the abscess soon improved, but continued to discharge until the 15th of June. On the 14th of March by neglecting to remove the plug from the catheter in defecating, the urine was forced around the catheter and made its exit freely from the perineal opening. This frequently occurred afterwards by the slightest effort of straining. The abscess was syringed freely with milk and a small quantity of liquor morph., after each occurrence, as well as the bladder, whenever there were symptoms of mucus or approaching vesical tenesmus, which always mitigated the patient's intense suffering. The shortest time the catheter remained in the bladder was four days, and the longest 13 days. The fistulous opening thus formed from the abscess remained about three months, through which urine frequently escaped freely towards the last without producing any pain or uneasiness. The catheter was retained in the bladder continuously for 68 days after the receipt of the injury, until prostatic pain occurred and blood began to ooze from the bladder. On consultation with my brother, Dr. Wm. Freeman, the catheter was removed. The volume of urine was greatly increased and came away without the slightest effort for five days, when it began to diminish gradually until the ninth day, when he was unable

to micturate. Number 8 catheter was passed with slight difficulty beyond the seat of stricture daily, and 9, 10, 11 and 12 were again used at intervals, but not allowed to enter the bladder. No. 11 was mostly used before micturition. This precaution was persevered with over a month, until a perfect cure has resulted in one of the gravest accidents which may occur to any person.

He had frequent attacks of orchitis, which were allayed by hot fomentations, and the subsequent use of the suspensory bandage. I would suggest the use of vulcanized rubber catheters in the treatment of analogous cases, as they do not become easily corroded by constant use.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—As a tribute to his worth, and as a matter of sad intelligence to many of your readers, I have thought a brief history of the sojourn, sickness and death of Dr. Ed. M. Hoople, of Toronto, Ontario, Canada, in this city, might prove acceptable to the columns of your very able and excellent journal. About six months ago, after an extended prospecting tour through most of our western States and Territories, Dr. H. reached this young metropolis of the south, "a stranger in a strange land." A partnership was suggested to him by a friend, and he called upon me with that object in view. I told him that though frequently solicited, I had never thought it expedient to take in a partner, but would very cheerfully extend to him the privileges of my office, and assist him in establishing himself with our people by every means in my power. From that hour until the advent of his last illness, he was my daily companion, friend and valuable assistant.

Dr. Hoople was a young man of thorough medical education; an honored graduate of the Royal College of Physicians and Surgeons, Edinburgh, and one who, had he lived, was destined to add lustre to the bright galaxy of names which already adorn the roll of graduates of that renowned institution. He was a man of modest, retired and cultured deportment, self-possessed in the confidence of his ability to "measure lances" with the best trained medical men of his age, from the thorough medical training to which he had been subjected,—yet, withal, having too much self-

respect to obtrude his opinions or judgment uninvited. His mind was analytic and quickly synthetic; his memory unusually retentive; his heart was unselfish and sympathetic, and his hands ever ready to assist those in need of help. He placed but little value upon money, save as a means of contributing to the comfort and happiness of others. With such a character as this, it is needless to say that in his new-found southern home, which he seemed to love with a pride and admiration as if begotten of many years of residence here, he soon won a host of friends, whose daily evidences of esteem in life, whose untiring and tender care and watchfulness during his illness and when death had cast its sable mantle over his noble frame, whose moistened eyes, soft and noiseless steps and low whisperings of love and sadness round his bier, more sweetly and beautifully attested their devotion, than empty words can express. He was fast gaining the confidence of our best people as to his professional abilities and skill, and had he lived, would soon have reached a self-sustaining if not a lucrative practice. He was fond of surgery and while here performed several skilful and delicate operations. He was taken down on the 25th of October with typhoid fever, complicated with hæmorrhage of the bowels, and died on the 3rd of November. I am greatly gratified to say to his aged mother especially—whom he loved and revered with the purest filial devotion—and his friends generally, that I believe he found peace, consolation and salvation by trusting in the atoning blood of Jesus Christ.

He had every attention that tender and skilful nursing could give. His prayers for the kind friends he had made, and especially for those who had waited and watched so lovingly and constantly over his sick bed, brought tears to the eyes of some unaccustomed to weep on such occasions. We feel comforted in the reflection that his was one of those cases in the experience of every physician, when every remedy has failed, which teaches us the impotency of man and the omnipotence of God.

Yours, etc.,

G. G. ROY, M.D.,

Prof. Materia Medica, Southern Med. Col.

ATLANTA, Ga., Nov. 25th, 1884.

Selected Articles.

REMOTE PUERPERAL HÆMORRHAGE.

Prof. T. Gaillard Thomas, M.D., of New York, gives the following in the *N. Y. Med. Jour.*, Sept. 6th:—Since I last attended a meeting of the society I have met two cases which have suggested to my mind the considerations which form the basis of what I am about to say. I refer to a form of hæmorrhage which comes on three weeks or a month after labor, after the physician has ceased making his visits. Some years ago the late Dr. M'Clintock, of Dublin, wrote a paper on this subject, and called it "remote or delayed puerperal hæmorrhage," and Dr. Mundé has recently written an article bearing upon the same point, published in the "*American Journal of Obstetrics*." I have seen a good many of these cases, and the history of one which I will relate illustrates the experience that I have had with most of them.

In such a case the uterus may have contracted after labor, and everything have gone on properly until the ninth day, when the physician has ceased to make his daily visits, but from that time the woman begins to lose blood steadily. If she makes a little unusual effort, or if anything occurs in the family to cause considerable mental excitement, an exceedingly dangerous hæmorrhage may take place, which will require to be checked with the tampon. If sudden and profuse hæmorrhage does not occur, demanding the services of a physician immediately, a steady loss of blood in moderate amount may continue for a week or ten days, until the woman becomes very much exhausted.

The particular case of which I have had the history in mind in the foregoing remarks, was that of a lady to whom I was called in consultation by a German physician of considerable experience. Ten months before, the patient had called at my office, and had given a somewhat peculiar history. She had been married for several years, her husband was a vigorous, healthy man in every respect, and she a remarkably handsome and well-formed woman; and yet no intercourse had ever occurred. On examination, it was found she was suffering from a very aggravated form of vaginismus. Her husband had exhausted all his efforts, and her mental state had become such that she could not entertain the thought of sexual intercourse. An operation was performed, at the end of a month the patient left the hospital, and just nine months later she was delivered of a child. About the end of the seventh month of gestation the veins leading from each labium majus became greatly enlarged, and the parts presented the appearance of a mass of earth-worms of the size of one's fist. I had seen the condition in so marked a degree but once or twice before.

On the ninth day after delivery hæmorrhage occurred, and she sent for her physician, who used all the ordinary means, including ergot, tannic acid, dilute sulphuric acid, etc., for stopping it, but without avail. The tampon, however, was not resorted to. About three weeks after her delivery the patient was seized with very profuse and violent hæmorrhage, which reduced her very much. It came on after she had got out of bed. When her physician reached her the hæmorrhage had ceased. Each time it had begun with the passage of a large blood-clot. On this occasion I was consulted, and I visited the patient three days later—the next time that hæmorrhage occurred. I took with me a nurse and instruments for dilating the uterine canal and for removing the remains of membranes. Her physician, however, felt very positive that none of the membranes had been left in the uterus, and stated that he had examined the placenta very carefully, and that there was no interruption of its continuity whatever. But I felt equally positive that some of the placenta yet remained in the uterus.

When the patient had been placed on the table and the ether-cone applied over her mouth, she suddenly sprang up in a state of wild excitement, and could not be induced to continue the inhalation of the ether, it had affected her so badly when she was operated upon for vaginismus. All means of persuasion were futile, and her friends desired that she should be compelled to take the anæsthetic. But I objected to compulsion, because, under such circumstances, after delivery, I have seen most violent and uncontrollable mania developed. In one instance the mania continued three weeks, during which time the patient was very violent, and had to be watched constantly by a nurse. It is true, the mania seemed to be of an hysterical nature, but, nevertheless, it was very violent. I think we cannot be too careful as to doing that which is strongly opposed to the will of a puerperal woman. I would rather have run the risk of a violent hæmorrhage in this case than have forced the patient to take the ether. She was spoken to kindly and put back into bed, and I assured her husband that she would send for me again within twenty-four hours, to have the operation done.

I was sent for the next day. The patient was then etherized, the uterine canal dilated, the curette was passed, and three pieces of placenta were removed, each as large as the last phalanx of one's index-finger. Very little hæmorrhage was excited by the operation, and I felt that in removing the pieces of placenta I had removed the cause of the hæmorrhage.

The points I wish to make are these. The case was an interesting one: 1st, with regard to the vaginismus; 2nd, with reference to the condition of the veins of the vulva; 3rd, with reference to the danger of giving ether during a state of maniacal

excitement; 4th, with reference to what I believe to be the usual cause of delayed puerperal hæmorrhage and the proper means for its cure.

With regard to the statement, so often made, that the placenta has been examined carefully and found entire, it usually amounts to nothing. In the first place, we know that the physician commonly looks at the after-birth hastily and in a careless manner. Besides, I believe that little pieces may be broken off and left behind, which no man could recognize from an examination of the placenta, though he examined it with the utmost care. As in this case, so in all others of delayed puerperal hæmorrhage that I have met with, it has been due to retained placenta or membranes. Dr. M'Clintock mentioned a case in his practice which, I believe, proved fatal. I have met with some which very nearly proved fatal, and doubtless some of those present have encountered similar cases.

TREATMENT OF ACUTE, PULMONARY GANGRENE.

Among the excellent voluntary papers presented at the last meeting of the Illinois State Medical Society, was a contribution to the surgical treatment of acute pulmonary gangrene, by Prof. Christian Fenger, M. D., of Chicago. The paper deserves and will elicit general attention, both from its intrinsic merit and as indicative of progress in American surgery.

As advised at the present time, four operations for acute pulmonary gangrene have been performed.

The first operation was performed in 1879, by Messrs. Lawson and Cayley, of England, in a case of five weeks' standing. Decided amelioration of symptoms, as regards cough, dyspnoea and fetor, was observed. The patient died of exhaustion four days after the operation. The autopsy disclosed facts which led the operators to believe that an earlier operation would have saved the patient's life. (Med. Society, London, 1880.) Mr. Solomon Charles Smith, of Halifax, performed the second operation in 1880. The patient was in the second week of croupous pneumonia, when gangrene occurred in the lower lobe of the left lung. The patient lived ten days, with marked improvement in cough, dyspnoea and fetor. No autopsy was made. Professor Buhl, of Christiana, performed the third operation in 1880. Acute gangrene in the anterior portion of the left lung was the indication for operation. After a long convalescence of six weeks the patient recovered.

The fourth operation was performed by Professor Christian Fenger, of Chicago, in the Cook County Hospital, in April, 1884. The patient, male, 34 years old, was in the second week of croupous pneumonia. Signs of consolidation and formation of a cavity in the right infra-mammary region,

extending into the right axilla, were elicited by auscultation and percussion. Cough was distressing and dyspœna great; about one pint of extremely offensive sputa was daily expectorated. The patient lost all appetite and rapidly progressive emaciation supervened. A cavity was found, upon the introduction of the needle of a hypodermic syringe through the thoracic wall, in the right infra-mammary region. An incision was made parallel to the clavicle; the ribs excised to an extent sufficient to secure access to the part, and the needle re-introduced within the cavity, as a guide. The cavity was then cut down upon by the small platinum pole of a Paquelin's thermo-cautery, and an opening sufficient to admit the index finger secured. Digital exploration revealed no detached gangrenous masses. Accordingly, the cavity was gently washed out, a drainage tube inserted, and the usual antiseptic dressing applied. Hemorrhage during the operation was trifling, but washing out the cavity produced very troublesome coughing. The patient speedily reacted from the shock of the operation, which was relatively slight. Five hours after the operation, appreciable diminution in the fetor was noted; at the end of the first week, expectoration was minimal, and fetor could not be perceived; at the end of the second week, decided improvement with return of appetite was observed; the fourth week witnessed further progress; and at the end of the fifth week the patient was out of bed. During convalescence bits of gangrenous lung tissue were discharged through the external opening.

With reference to the *technique* of the operation, Dr. Fenger recommends:—

1. The incision ought to be made parallel to the ribs.

2. The ribs must be excised to a degree sufficient to secure access to the part.

3. In conformity with the suggestion of Albert and Mosler, the needle of a hypodermic syringe should be used as a guide into the cavity, or diseased lung tissue, and the small platinum pole of Paquelin's thermo-cautery should be employed to effect the opening.

4. The cavity must be washed out if practicable. Due care must be exercised to prevent drowning, if the cavity connects with a bronchus. Irrigation of the cavity was productive of no untoward effect in Buhl's case, but was the cause of troublesome cough in Fenger's patient, and Mosler ascribes one death to poisoning from thymol irrigation.

Dr. Fenger is of the opinion that there is no danger of death from the operation, and that it is indicated in cases of acute, circumscribed, pulmonary gangrene.—*Chicago Med. Jour. and Examiner.*

THE USE OF CHLORIDE OF GOLD.

Dr. Bartholow, (*Med. News*) Aug. 2nd, 1884, says:

From the various sources of information now available, chiefly clinical, we learn that the preparations of gold possess those properties formerly entitled *alterative*, and now usually designated by the phrase *promoting tissue metamorphosis, or metabolism*, and the power to give stability to nervous matter, or the antispasmodic property. There are three several heads under which it will be convenient to group, for my purpose, the therapeutical powers of gold and its preparations, quite irrespective of its supposed physiological actions:

The so-called alterant effects;

The action on the nervous system;

The urino-genital properties.

Before undertaking to present the details under these several heads, it may be best to say something of the preparation used. I have always preferred the double chloride of gold and sodium, since I learned how little diffusible the chloride is. Injected subcutaneously in animals, the chloride seems not to diffuse through the vessel-walls, and when introduced into the blood tends to clog the kidneys. On the other hand, the double salt is readily diffusible. I have no experience with metallic gold or the oxide. Notwithstanding the chloride is so little diffusible, when taken into the stomach, effects are produced. It is probable that in the reactions which ensue the double chloride—of gold and sodium—is formed.

The usual dose of the gold and sodium chloride is one-twentieth of a grain. In this quantity twice or three times a day, it appears to have, as its primary action, the power to promote constructive metamorphosis, to improve the globular richness of the blood, and to increase tissue strength. However, kept up for a time, tissue changes become more rapid, and waste occurs in excess of repair. The tissues yielding most readily are, as might be expected, the connective, and especially those of pathological formation. Hence the utility of this remedy in *sclerosis*, whether nervous, hepatic, or renal. Especially in posterior spinal sclerosis, and in chronic interstitial nephritis, have I found the gold salt very efficacious. I am far from believing that lost parts may be restored, although some of my critics appear to think my credulity limitless. If used in locomotor ataxia, early and persistently, it has seemed to arrest the disease. It is true, since the publication of Strumpf's results with the faradic brush, I have not failed to make use of this method, but that it alone will stay the morbid process, I do not find. Before the electric brush had been employed systematically, I had witnessed the best results from gold and sodium chloride. During the last ten years, I have seen many cases in consultation, but of five in my immediate charge which I have followed, and in which the treatment was begun with the onset of the second stage, in three the disease seems not only to be arrested, but the condition improved. The knee-jerk, how-

ever, remains absent or feeble. The others are manifestly improved. Thus far, no persistent gastric or intestinal disorder has been caused by the remedy.

Excellent results have followed the use of the gold chloride in many cases of fibroid kidney, not only in my own hands, but in the care of other practitioners. Unquestionably the homœopathsists, guided in the use of this agent by the symptom—increased urinary flow, have had good results from the first dilution, but this topic is foreign to my present purpose.

There is a form of hypochondriasis, coincident with the onset of degenerative changes in the cerebral vessels—and it may be dependent on these changes, in which the gold and sodium chloride is very effective. It must be persistently used, and after a time the uneasiness in the head, the vertiginous and other abnormal sensations subside, the mental depression at the same time clearing up. Dr. Bauduy, of St. Louis, kindly informs me that he has had the same good effects. It seems to me that the ancient notion that gold is a "cordial" to the mind in the cases of melancholy, is also supported by modern experience.

In certain affections characterized by spasm, as asthma, laryngismus stridulus and singultus, this remedy acts surprisingly well sometimes. A physician with large experience in a malady which I do not see at all nowadays—pseudocroup, or laryngismus—informs me that he employs no other remedy, and his patients get speedy relief. There are various cognate affections in which, no doubt, it will be found in a high degree useful.

The same powers render gold a remedy of great value in certain urino-genital affections. I have referred to chronic interstitial nephritis. I could enumerate many instances of the more chronic cases of albuminuria, in which the curative effects of this remedy have been most conspicuous; but I am here concerned with the merely nervous affections. There are certain cases of sexual debility, accompanied by an extreme degree of hypochondriasis, which are amongst the most difficult and unsatisfactory with which we have to deal. No remedy has seemed to me so serviceable as this in this troublesome condition of things. In simple sexual debility, its administration promotes activity. In dysmenorrhœa with scanty menstruation, and in chronic metritis, accompanied by these symptoms, the persistent administration of gold and sodium chloride has done much good.

LITHOTOMY—LATERAL *vs.* HIGH OPERATION.

Sir Henry Thomson, in his lectures before the College of Surgeons, speaks of these two operations as follows:

There is unquestionably a growing expression of dissatisfaction among surgeons, especially abroad with the lateral operation for stones of unusually large size. I have for some time fully shared that feeling. No incisions can be made in the region which belongs to that operation through which a calculus of three ounces or more can be extracted. Laceration, either avowedly made by instruments or but half concealed under the name of gradual distention, invariably takes place, and that affecting very important structures, often to a large extent. Hence it is that the suprapubic operation has always invited consideration when the stone is exceptionally large; but the conditions sometimes met with, especially in corpulent subjects, have often presented peculiar difficulties and dangers, which indicated that, if Scylla has been avoided above, Charybdis appears to be equally dangerous below. A modification of the operation, however, has recently taken place—if not originated, at least first executed, by Professor Peterson, of Kiel, and described by him in 1880, which gives a new and improved position to the high operation. The improvement suggested consists in ensuring, to a degree not before attained, the raising of the bladder above the pubic symphysis, and the steady- ing of it in that position during the operation. These objects are thus attained. The patient, lying on his back, and under the influence of an anæsthetic, the bladder is first distended with weak solution of boracic acid, in quantity from ten to twelve ounces if possible, which must depend on the condition of the organ. The penis is firmly tied; nothing is better than an india-rubber tube for the purpose. Then a pear-shaped bag of india-rubber, tolerably stout, so as to retain that form, and capable of holding at least sixteen ounces of fluid, is folded longitudinally and introduced into the rectum. By the tube which forms its apex, and is supplied with a stopcock, water is forced in so as fully to distend the bag *in situ*. The outline of the bladder will now be traced above the pubic symphysis. The usual vertical incision is made, and dissection carried down to the bladder, with the usual precautions with which we are familiar. The ease and certainty, however, which are ensured by the firm position of the bladder on this system render it much superior to the old one.

I have operated by the high operation twice only, and that before the introduction of the new method. Since that time I have met with no case which I have not been able to deal with satisfactorily by lithotripsy at a single sitting, of which several examples are placed before you—the calculi weighing from one to nearly three ounces. The next case which offers for which the knife is required, I shall almost certainly submit to the high operation, with Peterson's modification. And the only reason why I have not yet performed it is, that I have easily and successfully employed

lithotripsy in cases precisely similar to those for which the French surgeons are adopting Peterson's procedure.—*British Medical Journal*.

CEREBRAL ABSCESS.—The antiseptic method of operating and after-treatment has not yet been fully tested in operations upon the brain. This is natural, for not only have we inherited a just dread of dealing with an organ, the large majority of whose diseases are dangerous or fatal, but our knowledge of the physiological functions of the brain and of their pathological modifications being extremely limited, we are not in a position to form such an accurate diagnosis as calls for surgical interference. Drs. Christian Fenger and E. W. Lee, of Chicago, in an extremely interesting paper on this subject in the July number of the *Am. Jour. Med. Sciences*, consider the treatment of traumatic cerebral abscess, and report a case which was successfully treated by opening and drainage.

Bergman, in discussing the treatment of cerebral abscess, unhesitatingly sets it down as an axiom that wherever there is an accumulation of pus, trephining is most clearly and indubitably indicated, for the opening of an abscess in the brain is as necessary as in any other part of the body, and we would add even more so. A correct diagnosis of abscess having been made, the further difficulty presents itself of locating it with sufficient accuracy, so as to be able to find it. A number of cases are on record in which a correct diagnosis had been made, the trephine also put on more or less on the right place, but the knife or trocar being passed into the brain nevertheless missed the abscess. Drs. Fenger and Lee show by their case that this difficulty can be obviated by multiple exploratory aspirations, performed at interstices sufficiently small to prevent any abscess from escaping detection, even if the trephine opening should not have been made at the point of the skull nearest the abscess.

There are on record a large number of cases of cerebral abscess in which trephining was performed, pus evacuated, and temporary relief obtained; but later relapse followed, and a fatal termination ensued. It is possible, judging from the success the practice has met with in the treatment of abscesses in other situations, that drainage of the cerebral abscess cavity, with or without washing out, would have saved some of these cases, by preventing the re-accumulation of pus and the continuous infection of the surrounding brain tissue, the acute œdema of which is well known to be, as a rule, the final cause of death. As far as Drs. Fenger and Lee are aware, draining and washing out of cerebral abscess cavities has heretofore not been tried; that it can be effected, and without any detriment to the patient, is shown by their case, the treatment of which they hold strictly conforms to the

rational method of modern surgery in treating abscesses in general; and because of this, and not because their patient recovered, they regard the case as answering affirmatively the question: Is it probable that abscesses in the brain can be treated advantageously on the same principle as abscesses in other parts of the body?—*Louisville Med. News*.

TREATMENT OF TAPE-WORM.—In the *Med. Times* of October 11th, 1884, Dr. Bernard Persh writes of the comparative value of the remedies used for the expulsion of the tape-worm. At a western military post a number of the men were troubled with this parasite, the writer being of the number. Turpentine, ether, pomegranate-root, male-fern, kooso, salicylic acid and carbolic acid were tried; and the best results obtained from the use of the last two named. Kooso was given in six drachm doses, suspended in water and followed by one ounce of castor oil. Two grains of carbolic acid were administered in a pill of extract liquorice; if, after a dose of castor oil this treatment failed, it was repeated on the following day. Large doses of carbolic acid may be given without producing disturbance of the digestive organs or carbolic acid poisoning; but in some cases even large doses of the acid failed to expel the worm. Several years after, the writer having been recommended to try croton oil and chloroform as a remedy, did so on himself, and it proved successful where the others had failed. Since that time he has used the treatment on more than twenty cases with excellent results. One drop of croton oil and a drachm of chloroform are suspended in an ounce of glycerine, and administered in the morning before breakfast. The only preparatory treatment consists of a half ounce of Rochelle salts given the preceding evening, which, although not necessary for a cure, facilitates the examination of the evacuations, prevents the breaking of the worm by hard fæces and allows it to pass more quickly through the intestines after becoming detached. The chloroform produces no bad effects; the slight giddiness and drowsiness sometimes noticed was relieved by the recumbent posture and disappeared when the croton oil commenced to operate. The oil acts rapidly, the bowels being moved in about an hour after its administration, and any tendency to diarrhoea or intestinal irritation is readily checked by bismuth and opium after the worm has been expelled. In one case the chloroform alone was efficient in bringing about the expulsion of the worm; but the fact that the worm is always expelled alive, showing that the chloroform, while compelling it to relinquish its hold, is not sufficient to kill it, renders the administration with it of a drastic purgative of rapid action, advisable. The author concludes by stating that in the cases treated successfully in this way, other remedies had been unsuccessfully employed. The patients agreed that

the remedy was readily taken, that its immediate effects were by no means unpleasant, and that the treatment did not leave them prostrated.—*Maryland Med. Journal.*

GLOSSO-LABIAL PARALYSIS.—Modern thought and research drift more and more to the position that the affection described by Duchenne as glosso-labial paralysis, and long supposed to be distinct, ought to be stricken from the list of diseases. In its typical form it is certainly only a localized chronic poliomyelitis, a mere variety of chronic muscular atrophy, in which the gray portion of the upper segment of the spinal cord—*i. e.*, the medulla oblongata—is especially attacked. It may exist by itself, or it may be associated with symptoms of palsy, due to poliomyelitis, in other parts of the body. In the latter case the medulla may be the first part of the cord invaded, the disease extending downwards, or the lesion may progress upwards and the medulla show the latest change. In a very interesting case recently shown at the clinic of Prof. H. C. Wood, the first symptoms were perceived by the patient in the mouth region, and subsequently the cervical cord became profoundly affected.

To grant these labio-glossal paralyses a separate state in our classification of disease would logically require similar treatment for cases of progressive muscular atrophy in each part of the body, since any spinal region may be attacked alone or separately.

The absurdity of the present separation of glosso-labial palsy is further shown by the circumstance that we may have such paralysis due to various apoplexies, brain-tumours, and other coarse cerebral lesions, and, to be logical, we should also isolate as a distinct disease cerebral glosso-labial paralysis.

In No. 20, *Archives de Neurologie*, is an important paper upon such an affection, by Dr. F. Raymond, in which illustrative cases are cited. The symptoms may, in case the lesion is a tumor, or other progressive alteration of brain-tissue, develop slowly, but they usually come on suddenly, because they are usually the result of clot or other apoplectic lesion, and, while they may develop alone, they are usually associated with other consentaneous palsies. Whether the manifestations come on slowly or rapidly, the cases are to be distinguished from those of medulla-disease by the absence of atrophic changes in the muscles affected, and by the preservation of the normal electrical reactions. The symptoms are stationary or progressive, as the case may be, *pari passu* with the cerebral lesion. The latter is either cortical or in the white matter. The general localization of the lesion of the white matter is in the lenticular nucleus or the external capsule, or sometimes in the internal capsule or peduncle. The foot of the ascend-

ing frontal convolution is stated to be the position in which cortical lesions cause the glosso-labial palsies.—*Medical Times.*

CHRONIC BRIGHT'S DISEASE.—Dr. Hiram Corson, Conshohocken, Pa., in a recent communication to the *Medical Times*, says: That a farmer, 46 years of age, complained for several months of ailments not uncommon in the beginning of Bright's disease, and finally sent for a physician, who finding his urine to be very albuminous, put him under the use of the various medicines recommended in that affection. Months passed; the limbs began to swell, and the anasarca was over the whole body. All the usual remedies of the day were applied, but with only the effect of temporary relief at times, to be followed by aggravation of the symptoms. When he was in this deplorable condition I remembered case upon case seen forty or fifty years ago, much like this, and proposed that we try the old plan. So we began to give, in pills, one grain of calomel, one of digitalis, and one of squill, three times a day, morphia or chloral, one or both, at night, to relieve oppression and induce sleep. Day after day we went on for two weeks, before the breath announced that the system was effected by the calomel, and all this time there had been no perceptible change save an increase in quantity of urine. But then all the symptoms showed an amelioration. The medicine was then used or omitted as seemed indicated. The object was to keep the system moderately under the influence of the mercury (what an awful word!) but not to push it to heavy salivation (another awful word!) From that time, every day showed an improvement—a rapid improvement—in the symptoms. Now, that is just what I will do for the first advanced case of Bright's disease that may come under my care.

HÆMORRHOIDS OPERATED ON WHEN INFLAMED.—Before the Kentucky State Medical Society at its recent session, held at Bowling Green, Prof. J. M. Mathews, of Louisville, addressing himself to this question, said:

"From a variety of causes, piles are liable to become inflamed, and once inflamed, they may easily become strangulated by passage below the sphincter. Everything is aggravated in this condition and it may take some weeks to quiet the trouble. It has occurred to me, why not operate upon and get rid of them at once? There is no authority that says "operate upon a pile during the inflamed state," but they will tell you to apply treatment to reduce the inflammation. I want to state one or two cases. A few weeks ago, I was called to a lawyer who was in this condition. The family physician in attendance had tried in vain to quiet inflammatory action, for two or three weeks. I found, hanging down from the anus, two solid

tumors; I passed the knife around them and ligated them. I visited him the following morning, expecting to find him in some trouble. To my satisfaction, he was out of the house in one week's time. Another case: A young man had a mass of inflamed tumors, hanging from him, larger than my fist. It would have taken several weeks to abate the inflammatory trouble and I ligated the whole mass. I went to see him next morning. I was told by the people at the house, that he had rested well all night, and got up early in the morning and went out. They sent for him but he could not be found. Three days later, I received a postal from Cairo, Illinois, saying that he was that far on his way home and was all right. When he got home he wrote me that he was entirely well; since then, I have had, I suppose, five or six cases of similar character, in which the proceedings and results were similar. I have, therefore, concluded that instead of applying remedies to relieve the inflammation in the tumors, they should be operated on at once."—*Am. Practitioner*.

THE TREATMENT OF SPRAIN BY THE ELASTIC BANDAGE.—This method of treating sprains has recently been recommended by Marc See (*Revue de Thérap.*). It is the only method which fulfils the two indications: 1. To cause as rapid absorption as possible of the blood extravasated around the joint (a lesion which controls all the other symptoms, such as pain, swelling, difficulty of movement, etc.); and, 2. To favor cicatrization of the torn ligaments and ruptured parts by complete immobilization.

The antiphlogistics and blood-letting, formerly advised by Hunter and Guersant, only partially fulfil the former indication. There is the same objection to the movements which Ribe and Bonnet advise for the injured joint. The refrigerants and cold-water baths advised by Baudens cause contraction of the tissues around the joint, and dispel inflammation, but they are not favorable to the absorption of the infiltrated fluids. Even massage, though superior to the other remedies just mentioned, fulfils only the second indication; furthermore, it is inconvenient, and requires much patience and time; and between the seances of manipulation the swelling reappears and the pain returns. It is true that massage has the advantage of removing the extravasated materials from the region of the joint toward the more vascular portions of the limb, where they are more easily absorbed. But the elastic bandage has this advantage in a greater degree, since its action is continuous. Finally, and above all, it favors immobilization of the joint, which is impossible during massage, and without which it is almost impossible to get cicatrization of the torn structures and complete recovery in sprains of any intensity. The bandage should be applied to the skin itself, care being taken to fill up the flat

and depressed places with wadding, so as to give a uniform surface around the joint for the bandage to act upon.—*Medical News*.

CHRYSOPHANIC ACID IN SKIN DISEASES.—Dr. Stocquart reports sixty-one cases treated by internal administration of chrysophanic acid (*Annales de Derm. et de Syph.*, Jan. 1884). No form of local treatment was employed. Of the sixty-one cases, fifty-six were entirely cured, and only one was unaffected by the treatment. The cases of acne, ecthyma, and impetigo, all yielded rapidly to the treatment, except one case of papulous acne. One case of pityriasis and three of urticaria were also quickly cured. In four cases of lichen and four of prurigo, the irritation was rapidly diminished, disappearing before the complete cessation of the eruption in lichen. Of thirty-two cases of eczema, thirty were cured. The author was struck with the rapid and complete cure of acute eczema and of impetiginous eczema in children. Out of five cases of psoriasis, three were cured. The acid was generally administered in water, the bottle being well shaken before use. In ordinary doses no patient objected to it; it was also prescribed in pills. The medium dose is one centigramme a day for children, and three centigrammes for adults. In these doses it is generally well tolerated; in large doses it may cause loss of appetite, nausea, palpitation, with præcordial distress and constriction of epigastrium, giddiness, vomiting, and cold shivers. This is an occasional occurrence only, and often much larger doses are well borne. Children tolerate the medicine well; at four weeks, he has given one, two, and in one case five centigrammes without provoking gastric irritation. Where the eruption is limited to parts ordinarily covered, and when the skin is not very thin or delicate, the external use of chrysophanic acid as an ointment is indicated. Where a great extent of surface is involved, the internal use is better. Phenomena of local irritation, or erysipelas, or, gastro-enteric symptoms, or nephritis, may be caused by the too free external use of the acid. Its internal use is also indicated when the eruption affects the hands or face. Where the stomach will not bear the remedy, it may be given hypodermically; but is then apt to cause pain and abscess. Its action is more rapid than when given by the mouth.—*N. Y. Med. Four.*

A MEDIEVAL RELIC.—At the recent meeting of the American Gynecological Association, Dr. T. Gaillard Thomas showed and made some interesting remarks about a medieval relic which had recently come into his possession. He had spent the past summer in a little, out-of-the-way Long Island village.

A friend in this village had recently received as a bequest, from France, some thirty large, old-fashioned trunks. These trunks contained old

MSS., books, jewelry, dresses, and odds and ends of all descriptions. In one of the trunks a very peculiar harness, which puzzled the gentleman, was found. It was submitted to Dr. Thomas. Upon examination, it was found to consist of a jointed steel girdle, covered with velvet—intended to encircle the waist of the wearer—and a semicircular rod of solid steel, with two circumscribed dilations, joining the circular girdle at right angles. It was evidently meant to be employed in the same way, though for a different purpose, as the female T bandage. The diamond-shaped dilatation, intended to fit accurately the vulvar orifice, was guarded upon both sides, on the inner edge with sharp steel teeth, pointing downward, forward, and outward. The circular ring designed for the anal orifice was provided with steel teeth in an identical manner. Armorial bearings were discovered upon different portions of the harness. Behind, at the point of junction of the girdle with the perineal rod, was the place for a lock, or rather seal. The diagnosis was plain. It was a *ceinture*, similar in shape and design to the girdle of *Diana de Poitiers*, which every one who visits Paris sees in the *Musée de Cluny*. The Crusaders were evidently in the habit of locking up home effects before their departure to the wars.—*Louisville Med. News*.

CANCER OF THE CERVIX UTERI.—Dr. Goodell gives the following method of treatment in the *Med. and Surgical Reporter*—"Having torn away all I can with my fingers, I inject pure vinegar, and now resort to the serrated curettes. With these the parts are thoroughly scraped, and with the gouge-forceps the vaginal portion of the cervix is removed. Next, with the platinum buttons of the thermo-cautery, I char the whole funnel-shaped wound. * * * The operation is now ended, and as there is no hemorrhage, I shall not tampon the vagina. But supposing you operate in the country at a distance from home, and you wish to guard against hemorrhage, or to stop an oozing, what do you do? You take a sponge and pass a string through the centre and tie the two free ends together in a long loop. Do not tie your string around your sponge, for you will then deprive it of its elasticity and the power of expanding. Prepare three sponges in this way, and soak them in vinegar. Pack the first sponge very firmly into the funnel-shaped wound, and make one knot in its string. The second sponge, with two knots in its string, will be pushed down to the cervix; and the third one, with three knots, will keep the other two in place. In twenty-four hours remove the sponge with three knots, and in forty-eight hours withdraw the sponge with two knots, and immediately afterwards the sponge with one knot. This last one must be removed carefully, and with a rotary motion. I do not put sponges in my patient's vagina

because she is in a hospital, in which some physician is always on hand. But supposing at 3 o'clock this afternoon the nurse finds our patient bleeding, what instructions shall I give our resident? He will first inject vinegar, and if that does not stop the hemorrhage, he will then pack the womb and vagina with sponges in the way which I have just described."

THE MEDICINES PHYSICIANS USE.—Squibb's *Ephemeris* gives an analysis, containing some points of interest of some observations made by Dr. Wm. P. Bolles on the prescriptions which he found on the files of three Boston pharmacists. The number counted was 3,726 which were pretty generally from physicians of that city. The number of articles entering these prescriptions was 504, the whole number contained in the U. S. P. for 1880 being 994. Of the 504, 236 occurred 5 or more times; 157, 10 times; 80, 25 times; 27, 50 times; 9, 100 times; 1, 200 times. Sulphate of quinine leads the list, and is found in 292 of the 3,726 prescriptions; sulphate of morphine in 172; bromide of potassium in 171; iodide of potassium in 155; tincture of chloride of iron, 134; subnitrate of bismuth, 133; glycerine and syrup together, 120; syrup, 108; carbolic acid, 92; extract nux vomica, 87; paregoric, 80; bicarbonate of soda, 77; calomel, 72; chlorate of potassium, 71; compound tincture of gentian, 67; lime water, 65; and so on down. It will thus be seen that of the 994 articles of the Pharmacopœia, only 18 occur more than 65 times in 3,726 prescriptions, and of these 18 three are vehicles or adjuncts which are in such common use as to bring their numbers into prominence. Dr. Squibb regards it as surplusage of a very useless kind to have a drug in substance, in *abstract decoction, infusion, extract, fluid extract, and tincture*. He says the individual habits of physicians are the cause of much of this surplusage. One of the remedies for this evil he points out as follows:—"The individual preferences of physicians are largely prejudices adopted from teachers in the schools, and, therefore, if the schools would but reason upon the subject, and direct only the best preparation of each drug, a needed reform in the Pharmacopœia would soon follow, and the pharmacists' supplies would be much fresher and more trustworthy.—*Med. Age*."

PLACENTA PRÆVIA.—Prof. Parvin (*Col. & Clin. Record*) says:—"While there is no single plan of treatment applicable to all cases of placenta prævia, in general, this treatment may be comprehended in the alliterative phrase, Temporize, tampon, turn. Temporize if the hemorrhage be not so great, and the pregnancy not near its end. Tampon if the hemorrhage be severe, and the os not sufficiently dilated for immediate delivery; but let the tampon be so applied that the hemorrhage will

be surely stopped and that dilatation of the os may be effected. Of course, a tampon can be most effectually applied if the perineum be drawn back by a Sims' speculum, and the os can be best dilated by a sponge-tent, or by means of Barnes' dilators, and these are to be preferred. If you use a vaginal tampon, do not soak the material in any astringent solution, for it is not by coagulating blood, but by pressure, you hope to arrest the flow. Of course, position is important, and you may also give cold acid drinks; opium and stimulants may be required if there be pain and prostration. Finally, turn—turn, because very often in placenta prævia the fœtus is transverse; turn, because when you bring the legs and then the thighs into the os uteri, you have a most effectual tampon; turn, because you can thus as a rule most quickly effect delivery; and the great dominating principle in the treatment of placenta prævia is, that when the hemorrhage is grave, end the pregnancy as soon as possible, both for the safety of the mother, and the safety of the child.

MORPHINE IN THE EARLY STAGES OF INSANITY.

—The responsibility of the physician in the use of morphia, in consequence of the possible development of the morphia habit, is great; but his responsibility relative to the possible disaster of a preventable life-long insanity, not prevented, is, if possible, still greater.

Auguste Voisin, of the *Salpêtrière*, Paris, claims for the use of the hydrochlorate of morphia, in gradually increased large doses long maintained, remarkable results in the treatment of certain forms of insanity. His theories are well sustained by physiological observations, and his cases are taken from the records of the *Salpêtrière* and private practice, and many of the cases have been examined after the lapse of several years.

In the article referred to, "Leçon Trentième," he gives a resumé of the history of the systematic use of opium and morphia in the treatment of insanity, and dates his own experience with it from the year 1867. His success was at first greatly diminished by the obstinate vomiting which frequently occurs; but on learning from M. Roller, Physician of the Insane Asylum at Illenau, France, that, regardless of the vomiting, the dose should be increased, he continued to increase the dose, and to that instruction he attributes his success. He has since treated successfully the various manifestations of insanity, which would seem to correspond practically to the first division adopted by the International Congress of Alienists in 1867, namely: simple insanity, comprehending mania, melancholia, monomania, circular insanity, moral insanity, in their early manifestations.

He uses exclusively the hydrochlorate of morphia, and only hypodermically, but fails to give the strength of the solution which he finds most

satisfactory. He does not mention the combination, so much appreciated in America, of morphia and atropia. Probably the association of the atropia is not to be desired. The efficacious dose desirable to sustain until the desired effect is obtained, can only be found by proceeding cautiously and studying each individual apart. One rule which the author never departs from, is not to exceed, in the initial dose, from one to three milligrammes. Whilst light cases associated with hallucinations are frequently relieved in a few days with a daily dose of from five to six centigrammes, yet in other cases the dose has to be increased to seventy centigrammes. He narrates one case in which two grammes of the hydrochlorate of morphia, in two doses, were administered daily, with no manifestation of its presence beyond a contraction of the pupils. The latter was one of the unsuccessful cases. He never entrusts the administration to a nurse.—*Four. Am. Med. Assoc.*

IS PAIN DURING THE FIRST STAGES OF LABOR NECESSARY?—In a communication to the *Obstetric Gazette*, Dr. I. W. Chisholm says that in answering this question I would say, from my own experience, and also from the observation of others with whom I have conversed on the subject, I have concluded that the pains incident to dilatation of the os during the first stage of labor are not necessary. My attention was first directed to this some years ago. Being called to see Mrs. G., whom I found suffering from the pains of the first stage of labor, being of the grinding character, and seemingly at regular intervals, I found, upon examination a rigid os and no signs of dilatation, and after waiting a considerable while I made another examination and found the same condition of things. I then concluded the pains were probably of the spurious kind, despite their seeming regularity, and gave her a dose of morphia, and in a short time she was entirely relieved and I took my departure. About ten o'clock in the evening I concluded I would call and see her before retiring, and on entering I found her resting comfortably, as she had been ever since I left in the morning after administering the morphia. I made an examination and found the os well dilated. I remained, and in a short time the second stage of labor came on, and the child was born in a few hours.

I was attending on Dr. P. at that time, and on calling on him in the morning I reported the results of my observations, he being a man of a large and extended experience of thirty-five years, said that he also had noticed the same thing, and always attended by good recoveries. Now if this is the experience of all who have tried it, why not relieve women of the painful ordeal of the first stage of labor?

A PIN SLING.—Samson Gamgee F.R.S.E., of

Birmingham, gives the following in the *Lancet*, Sept. 27th, 1884: A gentleman consulted me the other day, for a painful condition of the tip of his left little finger. To secure the benefits of physiological position and immobility, I bent the elbow at an acute angle and raised the hand; then, pinching up the sleeve at the wrist, fixed it to the coat with a safety-pin; with another I attached a fold of the sleeve to the coat just under the elbow. Rest was absolute; the finger waxed pale and easy; and my patient went to his office duties in comparative comfort.

Even if an ordinary sling be at hand, the process of fixing the forearm at an acute angle is not quite simple; and the resulting unsightliness is often unpleasant. With a little contrivance a pin sling may be made invisible. A third pin, fixing the inside of the arm sleeve to the body of the coat, adds greatly to immobility. In this position I have found one pin very useful, in steadying the shoulder of a young lady who had had it dislocated three times. She had barely recovered the last accident, when she was very anxious to go to a ball. By fixing, with a safety-pin, the inside of the sleeve to the bodice, a trusty yet invisible, checkmate was provided, allowing freedom of hand, but barring abduction. These are trifles, only noted apologetically, because, *pro re nata*, they may be useful.

CHLORATE OF POTASH IN TINEA.—Dr. C. C. P. Clark once had a case of tinea tarsi in a little girl. In spite of all the treatment recommended in the books, the morbid condition of the Meibomian glands persisted in pouring out their sticky exudation. Considering its efficacy when internally exhibited as an alterative in certain affections of the mucous membranes, particularly of the mouth and throat, the patient was given full doses of this medicine—about a drachm per diem. It worked like a charm. Repeatedly the disease returned, as is its wont, and was as often and as readily subdued. He has since constantly used this medicine in that complaint, and has never been disappointed.

Not long after a lad was brought to the doctor whose scalp was thickly bossed with huge, stinking, porriginous scabs. Reasoning from what was seen in the last-mentioned case, the same remedy was used to stay the morbid secretion in this, and with like good effect. The crusty hummocks disappeared, as a syphilitic node sometimes will under the use of the iodide of potassium, only far more rapidly. He who tries this remedy in this disease, in full doses, will not turn again to the scalp-shaving, poulticing, etc., which is the customary practice.—*N. Y. Medical Journal*.

THE HYPODERMIC INJECTION OF PILES.—Dr. J. W. Girard, of Winchester, Tenn., says "that the use of carbolic acid in hemorrhoids is condemned by the majority of leading physicians, but

successfully used by non-professional men." He further asks if there is not something radically wrong in the method of using the remedy, or in the act of condemning it, and continues: "If my experience with the use of the hypodermic syringe in hemorrhoids is worth anything to the profession I give it cheerfully.

"I have used it for about ten years, and have treated, I think, about two hundred cases without a single failure, and in no case has the tumor returned thus far. My course of treatment is generally to take one part of tannic acid, two parts of carbolic acid, four parts of alcohol, and eight parts glycerine. Inject each pile separately, and in a few days they slough away and generally heal kindly under dressings of carbolated cerate. If there is much constitutional disturbance, I generally control it with a steam bath or a hot sitz bath. My confidence in the method is so strong that I would persist in its use in spite of all that could be said against it. I would gladly answer any questions in my power that would enlighten any professional brother on the subject."—*Medical Bulletin*.

"TAKE YOUR FORCEPS WITH YOU."—Dr. H. V. Sweringen, of Fort Wayne, Ind. (who is well-known to our readers), contributes an article with this caption to the July number of the *Obstetric Gazette*, for the purpose of warning all physicians to be very particular always to carry with them to every labor case their forceps. It is well to issue such a warning occasionally, because on account of the very large proportion of cases of parturition that terminate spontaneously, the physician is very apt to leave his forceps at home, feeling that the chances are against his being obliged to use them, and if his home is far from his patient, and the demand for instrumental interference becomes very urgent, the patient may die before the forceps can be procured. Such a case has happened to Dr. S., and he concludes his article by saying, "I verily believe, that if she had been delivered promptly, with the forceps, immediately upon or before the appearance of her first convulsion, her life would have been saved. I close as I began, *take your forceps with you always*."—*Med. & Surg. Reporter*.

TREATMENT OF NASAL POLYPI.—As a valuable contribution to the therapeutics of this unpleasant condition, we are glad to note that Dr. Richardson, in the *Asclepiad*, recommends the use of sodium ethylate in the treatment of nasal polypus. The caustic agent is applied by means of a probe made of soft cotton-wool, twisted into shape on the points of a pair of forceps. This cotton probe is saturated with the ethylate, and then plunged into the substance of the polypus. On removing the cotton it commonly happens that the patient

can expel the whole mass of destroyed polypus, in a semi-fluid form, by blowing the nose sharply. A second application ought to be made with a view of destroying the base of the polypus. The mode of action is said to be sufficiently clear. The ethylate is decomposed by contact with the water of the polypus into caustic soda and alcohol; the latter coagulates the albuminoids, and the former acts as a powerful caustic. With the exception of some burning pain, no unpleasant effects seem to follow the use of this method.—*Ibid.*

USES OF MURIATE OF AMMONIA.—The *Med. Record* says: It increase the secretion of mucous from the alimentary canal, and is supposed to render the blood less plastic and coagulable, without impairing the structure of the corpuscles. Its habitual use causes emaciation, renders all the secretions freer and more abundant, and exerts an alterative and absorbent action, especially on the connective tissues, in hyperplasia and cirrhosis of many organs. It has even exerted some beneficial influence upon fibrous tumors of the uterus, and much more upon chronic engorgement of that organ. Its slow but steady modification of the nutrition of the connective tissues has been seen in chronic enlargements of the liver, spleen, prostate, thyroid and other enlargements. It cures many cases of gleet and if any internal remedy will relieve strictures of the urethra, this is the one most apt to do it. It cures some cases of neuralgia depending upon thickening of the neurilemma, and is one of the best remedies in fibrous phthisis. If other remedies fail, it should be tried in sclerosis of the cord and brain depending upon thickening and induration of the neuroglia.

MEMBRANOUS CROUP.—Dr. Jacobi says (*Med. News*) the mercurial treatment of membranous croup promises good results. The bichloride appears to be the best preparation for this purpose. The remedy should be given early and frequently repeated. The bichloride should be well diluted (about 1 to 3000). To babies about half a grain should be given in twenty-four hours, and, as a rule, its administration could be kept up for many days, if necessary, without bad effects. Stomatitis or salivation is very rarely observed, and gastrointestinal disturbances are not frequent under its use. If any unpleasant consequences result from the bichloride, inunction by the oleate of mercury is advised in its place. If the treatment of the diphtheritic disease be undertaken in time, the croup may often be prevented, as this is believed to be due to descending pharyngeal diphtheria.

HYSTERIA WITH UNILATERAL SWELLING.—Dr. S. Weir Mitchell records in the July number of *The Amer. Journal of the Medical Sciences* three cases of hysteria in which there was unilateral in-

crease in bulk at or near the menstrual period, and also at other seasons after emotional excitement, and he has been unable to find elsewhere any narration of similar cases. The writer cannot explain the causes of this phenomenon further than to say that they are under the influence of the nervous system, and vary with the causes which also increase or lessen the analgesia or give rise to chronic spasm. Most probably, he thinks, in many unilateral hysteric palsies a like phenomenon exists, and has merely escaped attention because of being the least prominent in a group of symptoms. At all events it adds another to the large group of resemblances which so closely relate organic to hysteric hemipalsy.—*Boston Med. Journal.*

BLISTERS AND SALICYLIC ACID IN RHEUMATISM.—The following are a couple of brief extracts from a clinical lecture delivered by Prof. Draper at the New York Hospital (*Med. & Surg. Rep.*):

Now a word about the use of blisters in the treatment of inflammatory rheumatism. We do not very often resort to them in acute cases of inflammatory rheumatism where there is a high temperature and great tenderness and swelling of the joints. And in my experience, they are not nearly so valuable here as in cases of sub-acute rheumatism. But where they are used in the very acute cases, it is almost invariably in connection with some other anti-rheumatic treatment, so that we do not get, I think, a true estimate of their value. But in those sub-acute cases where there is a moderate amount of infusion into the synovial cavities and some thickening of the tissues surrounding the joints, I believe that rest of the part and the local application of a blister are very valuable—while in cases of acute inflammation of the joints, I do not believe that blood-letting and counter-irritation are of much value.

There is one remark I wish to make about the salicylic acid treatment of rheumatism. I have told you before that of all the remedies which have been suggested for the cure of rheumatism, and their name is legion, none have given such satisfactory results or proven so valuable as salicylic acid. Now the history of the treatment of rheumatism constitutes a very remarkable chapter in the history of therapeutics.

There is no disease for which a greater diversity of remedies has been proposed. At one time acids were in favor, and at another time alkalies; at one time purgation was practised, and at another opium was used; and salts of every variety have at different times been supposed to have some superiority in the treatment of this disease. As a result, skeptics have arisen who doubt the efficacy of any treatment at all in rheumatism. So about fifteen years ago, at the time of the introduction of Fuller's alkaline treatment, Drs. Gull and Sutton treated a number of cases with simple mint-water, and their

results were as good as were obtained with the alkalis. They believed that all cases ran a regular course, and all had a tendency to end in a week or nine days, or in a fortnight, or else in the classical period of six weeks. But when you come to the salicylic acid treatment, there is no question as to its power. When you see, as we frequently do here, the greatest relief produced within twenty-four hours by the administration of ten-grain doses every two hours, and you find at the same time a great improvement in the appearance of the joints, I think that we get here not only a "post hoc" but a "propter hoc" argument to justify us in attributing the improvement to the use of salicylic acid.

OSTEOTOMY FOR GENU VALGUM.—Osteotomy for genu valgum was discussed at the International Medical Congress, and Macewen's supracondyloid osteotomy was acknowledged by all to be the most satisfactory one. Professor Ogston gracefully acknowledged that his own operation (fracture of the internal condyle) did not yield as good results as Macewen's simpler and safer operation. Professor Schede said that, with German surgeons, he had accepted Macewen's operation as the best. He differed from Dr. Macewen in doing his operation in one respect—he did not use but one chisel, and considered the withdrawal of the instrument from the wound a serious matter, in that it led to an unnecessary disturbance of the parts, and frequently some difficulty occurred in reintroducing the chisel. He thought that in many cases the tibia, rather than the femur, was involved, and in these cases he preferred his own operation (section of the tibia). Mr. Bryant complimented the gentlemen on the manner in which they had given up their pet operations, and had accorded to the supracondyloid operation (Macewen's) its just value.

INTRA-CAPSULAR FRACTURE OF THE FEMUR.—Dr. W. M. Fuqua is of the opinion that the "do nothing" plan of the older surgeons, in these cases, is wrong, and should be abandoned. Experience has shown that bony union can be had, and he thinks that every effort should be made to bring it about. He is satisfied that many of these fractures are through the inter-trochanteric lines, and therefore amenable to the reproductive influence of the periosteum. In the *American Practitioner* for October, 1884, he relates a case where, after ten or fifteen days' confinement to bed, he adjusted a well-fitting "Sayre's short splint," and placed the patient on his feet, having first lengthened the sound leg by the addition of an inch cork sole. With this appliance, and a crutch and cane, the patient walks about just as in a case of chronic disease of the coxo-femoral articulation. If the tendency to eversion, or possibly to inversion, be great, then "Sayre's long splint" would be required, night extension to be made by weight, and the

splint to be used during the day.—*Med. and Surg. Reporter.*

REDUCTION OF SUBCORACOID DISLOCATIONS.—Reduction of subcoracoid dislocations, as directed by Kocher, is accomplished as follows: Patient, sitting up, the forearm is fixed to a right angle with the arm, the elbow pressed firmly to the side of the chest; the arm rotated outward until firm resistance is met with; then the arm rotated inward. The last movement is one of restitution, and carries the shoulder opposite the one dislocated. These manipulations resolve themselves practically into two movements—outward rotation and flexion. Dr. C. A. Jersey (*New York Medical Jour.*, December 8, 1883), says the advantages of the method are:

1. The control obtained over the humerus by the position of the forearm.
2. The advantage obtained by the relaxation of the edges of the rent in the capsular ligament.
3. The absence of the necessity for the employment of an anesthetic.
4. The absence of pain to the patient and of discomfort to both surgeon and patient as compared with other methods.—*Medical Herald.*

TREATMENT OF BOILS.—Dr. John Aulde, following the suggestions of Dr. Sidney Ringer, has met with most satisfactory results by adopting the following plan. The diet is to be regulated and if constipation exists, a teaspoonful of magnesia sulph. in a glass of cold water should be taken every morning before breakfast:

R Calcii sulphidi grs. iij.
Sacch. lactis grs. xxx.
Misce bene et div. in chart., No. xxx.

Sig. Five powders daily at intervals, between meals.

By this method beginning boils will be aborted, and those far enough advanced to threaten a siege of several weeks and successive crops, will soften and heal in such short time that the patient will be surprised at the result. When they can be obtained, granules containing one-tenth grain are to be preferred to the powders. The urine should be examined for sugar, as boils and diabetes often go together.—*Summary.*

GUMMA OF THE BREAST.—Prof. S. W. Gross, says the *Medical Bulletin* (August), brought a case of gumma of the breast before the class last season, which was interesting, both because of the infrequency of its occurrence, and of its resemblance to malignant disease. Gumma of other parts of the body are met with almost every day in hospital practice, but it is extremely uncommon to find this manifestation of the syphilitic poison on the female breast. The patient, who was twenty-eight years old, and appeared to be in good health, complained

of trouble in the left breast. Examination showed a cake-like superficial tumor, involving the skin and subcutaneous connective tissue. The skin over the tumor was livid in color, and the nipple was retracted into it. These signs apparently pointed to superficial scirrhus. But from the absence of pain and axillary involvement, as well as the history of a dissolute husband and three miscarriages, Professor Gross concluded that it was a gumma. The woman was put on the mixed specific treatment, and the tumor disappeared in a short time.

LIVER SPOTS.—In an article on tinea versicolor, or liver spots, the *Med. and Surg. Reporter* says: The treatment is not difficult. The sulphur preparations are all useful, such as sodium hyposulphite, one drachm to the ounce of water; or Velminckx's solution, which is prepared as follows: Quicklime, one half ounce; flowers of sulphur, one ounce; water, ten ounces. Boil down to six ounces and filter. Perfume with oil of anise. This may be used diluted with four to eight parts of water, to be dabbed on the patches after a bath with soap and water. At the end of a week scarcely any sign of the disease will remain, and at the end of two weeks a cure may be effected. The result depends largely on the manner of making the application.

EXTIRPATION OF GOITRE BY MEANS OF THE ELASTIC LIGATURE.—Dr. S. Usiglio (*Gaz de Asp*), reports the case of a patient, æt. 56, who had enlargement of the thyroid body due to hyperplasia of the left lobe, in which the enlargement was removed by means of the elastic ligature. The part came away in five days and the patient recovered easily. Two months previously, in March, 1883, Dr. G. B. Masta had successfully employed the same means for the removal of a pedunculated tumor. De Vecchi and Castelleone have also reported cases. An incision is made into the skin in which the ligature is placed, the wound being disinfected and the ligature tightened daily.—*Practitioner*.

IN-GROWING NAIL.—In a note to the *Union Medica*, June 26, M. Monod states that during the last twenty years he has treated in growing nails by a very simple and effectual method, which does not involve the removal of the nail. He makes a free application of nitrate of silver at the commencement of the affection, without isolating the nail. If the cauterization is carried deeply into the diseased furrow, the patient has usually, even by the next day, derived considerable relief, and is able, even thus early, to walk in moderation with an easy shoe. Extirpation of the nail should be reserved for quite exceptional cases.—*Kansas City Medical Record*.

POSITION IN THE AFTER-TREATMENT OF LITHOTOMY.—Alex. Faulkner, of H. M. Indian Med. Service, says:

"I should like to bring to notice a point in the treatment of cases subsequent to the operation of lateral lithotomy, which I have practised for some time, namely, the advisability of continually keeping the patient lying on his abdomen after the operation. Although this mere position may seem at first an apparently trivial detail, yet I consider it is of importance in expediting the healing process of the perineal wound, as by its means the urine has a tendency to pass more through its natural course into the urethra when expelled from the bladder, instead of continually permeating through, and, consequently, irritating the open perineal wound."—*Med. Review*.

DR. J. A. LARRABEE, Prof. of Diseases of Children and Materia Medica and Therapeutics, Hospital College of Medicine, Louisville, Kentucky, says: Bromidia I regard as a more elegant and acceptable mode of administering safe and effectual hypnotics in childhood, than extemporaneous prescriptions. I have no doubt that Bromidia has supplied a want felt by many practitioners in diseases of infancy and childhood, preventing many from yielding to the temptation to use the various preparations of opium, which are so objectionable and dangerous.

INTESTINAL HEMORRHAGE IN TYPHOID FEVER.—At a recent clinical lecture, Professor Da Costa exhibited specimens from a case of typhoid fever in which death had occurred from peritonitis, with three recent perforations of the bowel. The patient four days before his death had had a profuse intestinal hemorrhage. The distinguished teacher took the opportunity of endorsing the ergot treatment of the hemorrhage, but insisted upon the importance of following it up with decided doses of opium in order to prevent perforation or to limit its effects.

OLEATE OF BISMUTH IN ECZEMA.—

R	Bismuthi oxid,	3 j.
	Acidi Oleici,	3 j.
	Ceræ albæ,	3 iij.
	Vaseline,	3 ix.
	Ol. rosæ	m ij. M.

Its action is particularly satisfactory in eczema of the hands.—*Von Hartingen in Philadelphia Medical Times*.

A medical student gave the following translation of the very correct Latin adage: "De mortuis nil nisi bonum": "From the dead nothing but bones." He was, probably, cousin-German to the young man who, in answer to a question declared Virchow to be the discoverer of vaccination.

THE CANADA LANCET.

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Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

THE PAST YEAR.

As is our custom at this season of the year we present our readers with a short *resumé* of the progress of medicine and some of the principal events which have transpired in the medical world during the past year. This we find, from the wide scope of the work, even in the necessarily imperfect manner in which it is done, to be no easy task, and we would gladly be relieved from the labor if we had the slightest reason to believe that it was not appreciated by the majority of our readers. The ceaseless activity in all departments of medicine renders it very difficult to follow with a critical eye all the new theories, methods, and appliances which have been advanced by enthusiastic admirers, yet there are a few prominent features connected with the progress of medicine, surgery, obstetrics and gynecology which it may be well to call attention to. Of all departments of medicine probably none have made more rapid strides than public hygiene. The subject is being continually pressed upon the attention of the governments both at home and abroad. Sanitary associations are being formed under favorable auspices, sanitary laws enacted, and governmental aid granted for the purpose of advancing the spread of knowledge among the people on subjects of the highest importance to their well-being. At no period in the world's history has greater attention been paid to sanitary science than at the present time. All this is the outcome of the teachings and repeated admonitions of the medical

profession, which is ever in the vanguard of all mental, social and physical improvement in the condition of the people; and in return for this we hope some day to see the claims of the profession more fully recognized and appreciated both by nations and individuals than they are at present. As a sign of the times, and as an earnest of the good things in store for the profession, we may mention the munificent gift of \$500,000 to the College of Physicians and Surgeons of New York by W. H. Vanderbilt, Esq.

In the elucidation of questions in etiology and pathology, great strides have been made. Close upon the heels of the discovery by Koch of the tubercle bacillus, comes the announcement of the comma bacillus by the same observer as the cause of cholera, and although there are those who are not prepared to accept all Koch says about these bacilli, he has not as yet been shown to be wrong in his conclusions. Other commissions have been appointed and we shall look forward to their reports with considerable interest. Pasteur's vaccination experiments, too, in connection with hydrophobia, have been put to the test with the most gratifying results, and from these small beginnings who shall say what grand results may be anticipated?

In medicine and therapeutics much valuable work has been accomplished. The use of convallaria maialis in heart disease has been more fully tested, and while the administration of the tincture in five minim doses has been attended with beneficial results in many cases, yet it requires, according to the experience of Dr. Herschell, care in the selection of cases. In one case in which he exhibited it in cardiac weakness and irregularity, the pulse became almost imperceptible, and there was great oppression, whereas digitalis caused rapid improvement in the patient's condition. Intra-peritoneal injections of albuminate of iron in cases of obstinate chronic anæmia have been recommended by Vachetta. He made numerous experiments on animals and never observed the least peritonitis as a result of the operation, and he regards it as safer than Ponfick's intra-peritoneal injection of blood. He recommends one to two grammes (15 to 30 grs.) of the albuminate of the Ammonio-citrate of iron dissolved in warm distilled water and injected through the abdominal wall near the umbilicus. Dr. B. W. Richardson (*Med.*

Times and Gazette) also advises *intra peritoneal* and intra-venous injections of warm saline solutions in the second stage of cholera. Kairine, so highly spoken of as an antipyretic, has on further trial failed to confirm the high estimate formed. Besides, it is expensive, disagreeable to the taste, and transitory in its action. The use of corrosive sublimate in diphtheria has been attended with very good results. It may be administered in doses of $\frac{3}{16}$ to $\frac{1}{12}$ of a grain every two hours to a child ten years of age. For topical application it may be made of the usual strength for dressing wounds. Among other uses to which corrosive sublimate has been applied during the year not the least is its application in the treatment of ringworm. Its efficacy is much enhanced by dissolving it in tincture of myrrh, in the strength of four grains to the ounce. The part is painted with the solution twice a day. In the treatment of infectious diseases, and especially typhoid, carbolic acid has been still further experimented with, the results being on the whole satisfactory. It is claimed by those who have tried it that the tongue remains moist, the diarrhoea is lessened, action of the skin is promoted, and the appetite early restored under its use. Dr. Wilks, of Guy's Hospital (*Med. Times and Gazette*) claims to have had very satisfactory results in the treatment of cases of diabetes mellitus with nux vomica and the mineral acids. The patient gained in weight, digestion was improved and the remedies seemed to have a specific action upon the glyconic function. Dr. Peyer, of Nottingham, Eng., (*Lancet*), utters a caution to medical men concerning the danger of using iodide of potassium internally and calomel externally, owing to the liability of the latter being formed into the iodide of mercury, and produce destructive action in the part. He gives his own experience in one case and refers to other published cases in support of his contention. The use of paraldehyde in the treatment of *delirium tremens* has again been brought forward by Prof. Gugl. He claims that it proves a prompt hypnotic, and in no case were there any unpleasant symptoms. The dose is from three to six or eight grammes. Dr. Galicer, of Versailles (*Bull de Therap.*), recommends the use of strychnine hypodermically in cases of paralysis. He maintains that used in this way it stimulates the muscles, producing a local as well as a general effect; in other words, it acts like elec-

tricity in paralysis. Notwithstanding the great success in the use of bichloride of methylene as an anæsthetic agent in the hands of Spencer Wells, it has not received much attention from the profession generally. This has no doubt arisen from the fact that two or three deaths occurred from its use when first introduced. M. Le Fort, of Paris, has been giving attention to this agent during the past year, and has come to the conclusion that it is superior to chloroform, inasmuch as the stage of excitement is much less marked and there is scarcely ever any vomiting. This is what Spencer Wells, who has used it in hundreds of laparotomies, always claimed for it. The external use of iodoform-collodion in the treatment of erysipelas has been highly extolled by Dr. Burman (*Practitioner*). He claims that it promptly relieves the burning sensation, reduces the swelling, and arrests the progress of the disease. In acute rheumatism the use of ten minims doses of oil of gaultheria is highly recommended by those who have given it a fair trial. This is not to be wondered at when it is remembered that this substance was the original source of that excellent remedy salicylic acid. In the treatment of angina pectoris with sodium nitrite further successful cases have been published during the year. It should be given in three to five grain doses, as larger quantities are likely to produce unpleasant symptoms. The value of bromide of sodium in the treatment of epilepsy has been made the subject of investigation by Prof. Germain Sée, the result of which is to increase general confidence in its use. He says the efficacy of the drug rests almost exclusively on the depressing influence it exercises on the reflex action of the spinal cord and medulla, and he would therefore rigidly proscribe all stimulants of every form—such as alcohol, tea, coffee, etc. Further use of nitro-glycerine in this affection also shows its value in certain cases in arresting the frequency and violence of the fits. The dose is from one to two drops of a one per cent. solution three or four times a day. As a means of distinguishing between simple ectasis or dilatation of the stomach, and that due to stricture of the pylorus from carcinoma, the fact first pointed out by VanderVelden, and recently investigated by Dr. Kredel, of Giessen, viz., that free hydrochloric acid is absent in the ejecta in cases of carcinoma, is, if true, a most significant and valuable

aid in diagnosis. The results of Dr. Kredel's researches are not only most assuring, but they also afford a hint for the medicinal treatment of these unfortunate cases.

In the domain of general and operative surgery there are many interesting facts to record during the year. A valuable point in intestinal surgery has been given to the profession by Dr. Rand in the *LANCET*, viz., a means of identifying the upper and lower ends of any given piece of small intestine. The mesentery is the guide. Holding the bowel in its true direction, and passing the hand on the right side back to the spinal attachment of the mesentery, it will be on the right side of the spine; but should the apparent upper end be in reality the lower, or, in other words, be held in the wrong direction, the hand passed to the right of it will pass to the left of the spine, and *vice versa*. Mr. Lawson Tait, in the (*Brit. Med. Journal*), gives his method for the radical cure of umbilical hernia by abdominal section, and considers it applicable to other forms of hernia. He opens the sac, frees all adhesions, cuts off omentum that may be in the way, pares the edges of the ring, and stitches up the wound with a continuous silk thread which he leaves permanently. The results have been most satisfactory. The subject of rectal etherization was brought prominently before the profession during the early part of the year, but though taken up with alacrity at first, seems already to have been almost entirely lost sight of. This is to be regretted, as there are no doubt cases in which this method of producing anæsthesia is valuable—such as operations upon the mouth, throat, and palate. We gave in our columns at the time full instructions as to its mode of administration. An improvement upon the ordinary operation for cancer of the rectum has been proposed by Mr. Pollosson. It consists in first making an artificial anus at the sigmoid flexure, and subsequently removing the cancer of the rectum. His idea is, that by this method the rectum is rendered passive and inert before extirpation, and many dangers are thereby avoided. The removal of a cancer of the anus and rectum was successfully performed in the Toronto General Hospital by Prof. Fulton, of Trinity Medical College. The entire anus and three inches and a half of the rectum were removed. The subject of so-called "catheter fever," was brought under the notice of the profession by

a paper read before the London Medical Society, by Sir Andrew Clarke. By catheter fever is meant a severe and sometimes fatal form of fever following the use of the catheter in apparently healthy persons, in whom no lesions to account for death can be found post mortem. As a preventive he advises the use of opiates or anæsthetics, in cases where trouble of this kind may be expected, or has previously occurred. The general opinion of surgeons on this subject, however, is that what Sir Andrew Clarke alluded to was not new, but only one of the forms of urinary fever which follows the use of the catheter. The surgical treatment of large bronchoceles, has been discussed from various points of view. Some recommend their removal by the knife, tying all large vessels entering the tumor before division, so as to prevent loss of blood. Others have successfully treated them by the seton. Another method consists in cutting down upon the isthmus and applying a ligature at its juncture with the lateral lobe on each side and removing the isthmus. In a case operated upon in this way, by Mr. Sidney Jones, great relief from dyspnœa followed. The application of an elastic ligature around the base of the growth has also been quite recently recommended. The treatment of senile gangrene was the subject of discussion before the Royal Chirurgical Society, London. Mr. Jonathan Hutchinson read a paper recommending amputation high up in all cases of senile gangrene, viz.: in the lower third of the thigh and the middle of the arm. In the discussion that followed Mr. Savory said that if the causes were chiefly local, amputation might be successful, but if constitutional it would not, and in such cases he would prefer to leave it to nature. A little later on a very important paper was read before the above named society by Mr. F. Treves, on the direct treatment of spinal caries by operation. In cases of commencing psoas abscess, he cuts down along the outer border of the erector spinæ, opposite the last dorsal and first lumbar vertebræ—the most common site of abscess, gives exit to the pus and removes any sequestra of bone which may be found. In one instance he evacuated 40 ounces of pus and removed a large sequestrum from the body of the first lumbar vertebra. The improvement in the patient's condition was immediate. Several interesting and important cases of suturing the intestines have been reported,

besides experiments on the lower animals, to determine the best method of treatment. The results of treatment in these cases have been such as to lead us to adopt active surgical interference in all cases of traumatic lesion of the bowels. A modification of the Lembert interrupted suture is the one most strongly recommended. The late Prof. Gross, in a paper republished in our columns, very properly, we think, recommends the interrupted silk ligature in preference to catgut. Dr. McDonald, of Edinburgh, reports a case in the March number of this journal, in which he removed several inches of the small intestine, in the course of an abdominal section for extra-uterine pregnancy. The patient made a good recovery. A very interesting case of gastrostomy is reported by Prof. Loreta (*Lancet*), for stenosis of the cardiac orifice. After making an opening into the stomach, the cardiac orifice was dilated by means of a suitable instrument, and the patient made an excellent recovery. Resection of the lung in acute pulmonary gangrene has been successfully performed by Dr. Fenger, of Chicago. In this case an incision was made parallel to the clavicle, the ribs excised sufficiently to permit of the operation, and an opening made through the lung tissue into the cavity with the thermo-cautery. Portions of the putrefied lung tissue were discharged through the opening, and the patient made a good recovery. In the matter of osteotomy for genu-valgum, Dr. McEwen's supra-condyloid operation has come to be regarded as the most successful in its results, and at the International Medical Congress this fact was publicly acknowledged.

Nerve suturing has been again still further put to the test. A case is reported in the *Brit. Med. Journal*, Nov. 29th, in which Prof. Von Bergmann removed two inches of the shaft of the humerus in order to be able to unite the nerves which had been widely separated as the result of a wound by a circular saw. Successful cases of extirpation of the spleen have been chronicled from time to time during the year. A successful case was recently reported by Von Hecker, assistant to Billroth. So far there have been 36 cases of extirpation of the spleen. Of these 24 were for leukæmia, of which only one recovered.

The antiseptic treatment of wounds, *a la* Lister, is still being carried out by his disciples in all parts of the world, but the antiseptic agents used are

being changed from time to time. Corrosive sublimate dissolved in blood-serum (1 part to 100) is the agent recommended by Mr. Lister at a recent meeting of the London Medical Society. The introduction of the new local anæsthetic muriate of cocaine in ophthalmic and general surgery will within certain limits undoubtedly prove of great value to the profession. It is easily applied and its anæsthetic effects are sufficiently complete to render it useful in operations where a transient effect is all that is necessary.

In the matter of obstetrics and gynecology there has been much material progress. In the early part of the year the subject of puerperal fever occupied the attention of some of the most prominent gynecologists, and much was said and written regarding the use of prophylactics, the practical outcome of which was to impress upon the professional mind the oft-repeated maxim that cleanliness is the greatest of all prophylactics. As is usual in human affairs there was a tendency manifested to go to extremes in regard to the measures to be used to prevent the occurrence of puerperal fever, septicæmia, etc. Dr. Thomas, who read a paper before the N.Y. Academy of Medicine, strongly advocating the most active interference in the puerperal state, afterwards so far modified his former expressions of opinion as to bring them into harmony with those who advocated less active measures. The combined method of turning in placenta prævia has again been brought more fully under the notice of the profession by Dr. Behm, of Berlin. The advantages claimed for this method are the avoidance of sepsis and the limitation of the loss of blood, from atonic post-partum hemorrhage. His plan is to leave the case entirely to nature after getting the breech down to the os—"haste" in performing combined turning, "delay" in extraction. The application of the forceps to the breech in certain cases has also been advocated by Truzzi (*Gaz. Med. Ital.*) contrary to the teaching of former times. He regards their use as preferable to traction on the groin by the finger, fillet or blunt hook. Porro's operation has been the subject of earnest discussion, by some of the leading gynecologists during the year. Dr. Godson read a very interesting and valuable paper on this subject before the British Medical Association in Belfast, giving ample data upon the status of the operation from a statistical point of view. In 131

cases the total mortality amounted to a fraction over 55 per cent. from which he is warranted in drawing the inference that the operation is one from which most satisfactory results may be obtained in properly selected and managed cases. Too many such cases are put off until it is too late to expect a successful issue. In the vomiting of pregnancy, iridin has been recently most enthusiastically praised as a remedy. M. De Musy (*Progrès Medical*) stated at the Société de Therap. that the Edinburgh physicians has used it extensively. Dr. Berry Hart had used it in ten cases without a single failure. The dose is three grains in pill form with conserve of roses every night, followed by a saline purgative in the morning. Hydrastis Canadensis has been used with great success by numerous observers both at home and abroad, in the treatment of uterine hemorrhage, and the results have been on the whole most satisfactory. It appears to produce contraction of the arterioles and lessen congestion, its action being somewhat similar, but more reliable than ergot. The dose is ten to twenty minims of the fluid extract. In the treatment of uterine displacements, Dr. Bell (*Lancet*) claims to have had excellent results from the use of medicated tampons. The substances he uses are alum, carbolic acid and glycerine, which he says support, deplete and invigorate the uterus and vagina. Mr. Lawson Tait reports (*Brit. Med. Four.*) five cases of laparotomy for extra-uterine pregnancy, with four recoveries. The diagnosis in these cases is perhaps the most difficult part, but Mr. Tait never hesitates to open the abdomen. If a patient has been eight weeks or more without a period, and a pelvic mass can be felt on one side of the uterus and fixing it, and if sudden symptoms of pelvic trouble and hemorrhage come on, rupture may be suspected and abdominal section should be performed at once. Mr. Tait in his address on abdominal surgery at the meeting of the Canada Medical Association, gave us some idea of the reason of his remarkable success, viz., entire restriction to his chosen field, minute attention to every detail, together with great attention to cleanliness in every part of his work.

The association meetings during the year were more than usually well attended, and an increasing interest was manifested in all the proceedings. The various Provincial Associations in Ontario,

New Brunswick and Nova Scotia, were well attended, and much valuable work was accomplished. The New Brunswick Medical Association decided to enter upon the experiment of publishing a quarterly medical journal, but we have not yet seen the first number. The Canada Medical Association met in Montreal in August under the presidency of Dr. Sullivan of Kingston, and under the most favorable circumstances. The interest of the meeting was greatly enhanced by the presence and active co-operation of members of the British Association for the advancement of science. Many instructive and valuable papers were read and discussed, not the least of which was the admirable address on abdominal surgery by Mr. Lawson Tait. The profession of Montreal in their hospitality exceeded all previous efforts, and both the social and intellectual proceedings were highly spoken of by all who participated. Dr. Osler was elected President for the ensuing year, and Winnipeg was chosen as the next place of meeting on the third Tuesday in August, '85. The American Medical Association met in Washington in May, under the presidency of Dr. Flint, Sr. Upwards of 1200 members were present and the meeting was most successful in every respect. The code, contrary to what was expected in some quarters, occasioned no difficulty. The work of the session was well sustained. The Journal of the Association came in for a share of criticism, but it was decided to give it another year's trial. Dr. Campbell, of Georgia, was elected president, and New Orleans chosen as the next place of meeting on the last Tuesday of April, 1885. The meeting of the British Medical Association was held in Belfast in July, Dr. Cuming, president, in the chair. A number of distinguished foreigners were present, besides delegates from the United States and Canada. Able addresses were delivered on medicine, surgery and obstetrics, and the work of the sessions was earnest and active. The social aspect was of the most brilliant and hospitable character. The eighth session of the International Medical Congress opened in Copenhagen on the 10th of August, under most favorable auspices. The attendance comprised about 1600 medical men of all nationalities. The meeting both intellectually and socially was a great success. The next meeting is to take place in Washington, in 1887, under the presidency of Dr. Flint, Sr.

During the past year the following new books and new editions of old ones have been issued from the press:—Syphilis in New-born Children and Infants, Diday; *Materia Medica and Therapeutics*, Bartholow; *Student's Manual of Chemistry*, Witthaus; *Operations of Surgery*, Bell; *Pathology and Treatment of Venereal Diseases*, Bumstead; *Roller Bandage*, Hopkins; *Medical and Surgical Uses of Electricity*, Beard; *Manual of Diseases of Nose and Throat*, Kitchen; *Oral Surgery*, Garretson; *Hand-book of Chemistry*, Greville; *Hand-book of Skin Diseases*, Kippax; *Influence of the mind upon the body*, Tuke; *History of Tuberculosis*, Spina; *Manual of Practical Hygiene*, Chaumont; *Bright's Disease of Kidneys*, Millard; *Practical Pathology*, Woodhead; *International Encyclopædia of Medicine*, vol. iv., Ashhurst; *Dictionary of Medicine*, Quain; *Treatise on Pharmacy*, Parrish; *Therapeutic Hand-book of U. S. Pharmacopœia*, Edes; *Manual of Obstetrics*, King; *Treatise on Surgical Diagnosis*, Ranney; *Epitome of Skin Disease*, Fox; *Guide to American Students in Europe*, Hun; *Hand-book of Forensic Medicine and Medical Police*, Husband; "Shakespeare as a Physician," Chesney; *Elements of Pharmacy, Materia Medica, and Therapeutics*, Whitla; *Opera Minora*, Seguin; *Elementary Principles of Electro-Therapeutics*, Haynes; *Medical Ethics*, Hamilton; *Elements of Surgical Pathology*, Pepper; *Clinical Lectures on Mental Diseases*, Clouston; *Brain Exhaustion*, Cornell; *Deutch's Medical German*; *Diseases of Rectum and Anus*, Kelsey; *Gonorrhœa*, Milton; *Obstetrics*, Verrier; *Diseases of Heart*, Paul; *Eczema*, Buckley; *Second Annual Report of Ontario Board of Health*; *Clinical Chemistry*, Ralfe; *Dissector's Manual*, Clarke; *American System of Practical Medicine*, Pepper; *Electro-Therapeutics*, Amidon; *Diseases of Throat and Nose*, McKenzie; *Diseases in Children*, Smith; *Manual of Obstetrics*, Partridge; *Auscultation, Percussion and Urinalysis*, Leonard; *Visions of Fancy*, Baskett; *Hooper's Physician's Vade Mecum*; *Materia Medica and Therapeutics*, Bruce; *Principles and Practice of Medicine*, Davis; *Practical Medicine*, Loomis; *Malaria and Malarial Diseases*, Steinberg; *Diseases of Women and Uterine Therapeutics*, Jones; *Medical Rhymes*, Erichsen; *Lock-jaw of Infants*, Hartigan; *Fractures and Dislocations*, Hamilton; *Science and Art of Surgery*, vol. i., Erichsen; *Pathology and Morbid Anatomy*, Greene, etc.

Among those of our confrères who have passed away during the year, may be mentioned,—S. F. Whitman, Bridgetown, N. S.; H. Bennett, Priceville; J. Reddy, Montreal; J. Thomson, Chatham, N. B.; J. R. Tabor, Whitevale; A. C. Savage, Chicago; J. R. Smith, Harrowsmith; C. H. Lavell, Kingston; R. Black, Wickham, N. B.; E. Clay, Halifax, N. S.; J. F. Coad, East Zorra; C. Deguise, Quebec; Wm. James, Burgessville; P. N. Leclair, North Lancaster; S. W. Cooke, Paris; —. Kittson, St. Paul, Minn.; J. J. Dickinson, Cornwall; R. Stephen, Digby, N.S.; J. E. Landry, Quebec; H. Maudesley, Moorefield; H. C. Fixott, Arichat, N. S.; E. Morton, Queensville; G. A. Kent, Wallace, N. S.; J. A. Aikman, Ingersoll; J. S. Diamond, Toronto; G. Willcock, Toronto; E. Jennings, Halifax; G. H. Nelson, Santa Barbara, Cal.; Jas. McCammon, Kingston; A. B. Craig, Montreal, etc. Among those in foreign lands may be mentioned,—Prof. Balfour, Alex. Wood and Allan Thomson, Edinburgh; C. H. Hawkins, London, Eng.; Prof. Jäger, Vienna; —. Radcliffe, England; Prof. Cohnheim, Leipsic; Profs. Gross and Rogers, Philadelphia; Prof. Parker, New York; Dr. Dugas, Georgia; Dr. L. P. Yandell, Louisville, etc.

The outbreak of cholera during the past year in the south of France and its extension to other points in Europe, and recently to Paris, strikes the note of alarm, and bids us prepare to ward off the impending blow. Our sanitarians in Canada and the United States are united in making representations to their respective governments, with the view of dealing promptly with the adversary should it unfortunately reach our shores. Various outbreaks of smallpox and diphtheria have taken place at different times and in different localities, but upon the whole the health of the community has been no worse than in former years. We conclude by wishing our many readers a happy new year, great and increasing prosperity, and long lives of usefulness.

JAMES McCAMMON, M.D., M.R.C.S., ENG.

Dr. McCammon, whose death recently took place, was born in Kingston, Ont., in 1833, and there received his primary education. On reaching manhood he first devoted his attention to school teaching, after qualifying himself for the duty by

attendance at the Normal School, Toronto. He followed this occupation with remarkable success for several years, after which he turned his attention to the study of medicine, and graduated with honors in Queen's College in 1863. He subsequently practised for several years in Newburgh, Ont., where he acquired a lucrative practice. In 1871 he visited the European hospitals determined to acquire experience and obtain a wider knowledge of surgery and physic. He there obtained the diploma of the Royal College of Surgeons, Eng., and on his return settled in Kingston. He was for several years a member of the Ontario Medical Council, and was recently appointed to the chair of clinical surgery in the Kingston Medical School, which position he filled with marked ability and favor. He was also a member of the Council of Queen's University. He was elected mayor of his native city in January last, and was most assiduous, as indeed in everything else, in the performance of his civic duties. In the death of Dr. McCammon the profession of Canada has lost one of its most active and intelligent members and the city of Kingston its chief magistrate and one of its most valuable citizens. The sick poor of the city have lost a sincere and self-sacrificing friend, and his wife and family a devoted father and husband.

THE LYNAM CASE.—About two years ago Mrs. Lynam was considered insane, and was sent to the Longue Point Asylum by the certificate of the visiting physician. Recently a Mr. Perry, who interested himself in her behalf, became convinced that she was sane, and applied to Judge Jette to have her produced in court, in order to test the question of her sanity or insanity. Experts, or so-called experts were called to testify, and as is usual under such circumstances, some of them declared her insane, while as many of equal authority pronounced her sane. The judge was, of course, bewildered, and accordingly put Mrs. Lynam in the witness box, and is said to have given her a most severe examination, which she bore with great calmness and fortitude. He finally decided to appoint Dr. Vallee of the Beauport Asylum, to examine her, and suggested that the Quebec Government should appoint two others to act in conjunction with him. The government have been

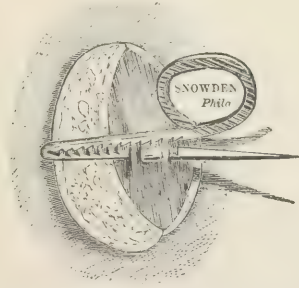
dilatory in the matter, but Dr. Vallee has visited Mrs. Lynam, and has filed his report in the superior court, declaring her in his opinion, to be sane.

ARTERY-COMPRESSOR.—A convenient and effective appliance has been devised by Dr. Levis for the rapid arrest of hemorrhage in large open wounds. It is exceeding simple and inexpensive.



Numbers of the compressors can be quickly applied during an operation, and the surgeon may leisurely ligate the vessels if after their removal, the ligature should be required. In many operations attended for the time by great hemorrhage from numerous small vessels, the temporary stasis produced by the compressors will be sufficient to prevent further flow.

By this device the operator can proceed to the end of an operation without stopping to apply ligatures.



The instrument and its application are so illustrated in the cuts that description is unnecessary. The compressors are made by Snowden, 7 South Eleventh Street, Philadelphia, and the price is only 25 cents each.

SUBCUTANEOUS INJECTION OF MORPHIA IN CHOLERA.—Dr. Brown, of Clayton, Ont., has called our attention to the following which was published in the LANCET several years ago, and which we now re-publish: "Dr. Patterson, of Constantinople (*Braithwaite*), reports that in the late epidemic of cholera in that city, finding all other treatment unsatisfactory, he determined to try the subcutaneous injection of morphia. In the first case a quarter of a grain of the acetate caused relief to the cramps and vomiting in a quarter of

an hour, and the skin became gradually warm and moist, and the pulse returned. In ordinary cases he found one or two injections sufficed, in a few three were given, and only once four. He does not maintain that the treatment is a specific against cholera, but that its action is more speedy, certain and effectual than any other tried by him. Out of thirty-two cases in which the treatment had a fair chance, there were only ten deaths."

MORE ADVERTISING IN THE LOCAL PRESS.—Inasmuch as the LANCET is again on the war-path, the following "most extraordinary case" under the care of Dr. Hamilton, of Port Hope, Ont., may be alluded to. The item, which appears to have been written, or at all events the facts supplied by a medical man, appeared in the *Port Hope Guide*, Dec. 5th. A young man was wounded in the orbit by a piece of wood. The doctor, after "probing the wound, discovered a foreign body," and advised an operation. He gave chloroform, "enlarged the wound," and on laying hold of the "foreign body" with a "strong forceps," removed it, &c. We leave our readers to judge of the paternity of the offspring.

INTERNATIONAL MEDICAL CONGRESS.—The Committee on Organization of the 7th International Medical Congress, to be held in Washington in 1887, met recently and the following officers were elected: *President*, Dr. Austin Flint, Sr., New York. *Vice-Presidents*, Dr. Alfred Sille, Philadelphia; Dr. Henry I. Bowditch, Boston; Dr. R. P. Howard, Montreal. *Secretary General*, Dr. J. S. Billings, U. S. Army; *Treasurer*, Dr. J. M. Browne, U. S. Navy. *Members of the Executive Committee*, Dr. I. Minis Hays, Philadelphia; Dr. Jacobi, New York; Dr. Johnston, Baltimore; Dr. Busey, Washington.

REMOVAL OF LARGE CALCULI.—Dr. Hingston, of Montreal, removed from the bladder a calculus weighing five ounces and five drachms, and measuring upwards of nine inches in its greatest circumference. The lateral method was adopted and the patient, a youth of 21 years, made a rapid recovery. Dr. Burns, of the Toronto General Hospital, also removed a calculus from the bladder a few months ago by the supra-pubic method, weighing three and a half ounces, and measuring two and three quarter inches in its greatest diameter. The

patient, aged 21 years, unfortunately died within 24 hours.

REMOVAL OF A TUMOR OF THE BRAIN.—Mr. Godlee recently removed a tumor from the substance of the brain at the hospital for epilepsy and paralysis, London, Eng. The case was under the care of Dr. Hughes Bennett, who diagnosed the existence of a tumor in the upper part of the fissure of Rolando, and requested the surgeon to trephine over the suspected region. A mass of glioma the size of a walnut was successfully removed and the patient had progressed favorably up to the time of writing.

SANITARY CONGRESS.—Dr. C. W. Covernton, Chairman of the Ontario Board of Health, has been requested by the Dominion Government to represent Canada at the Sanitary Congress held in Washington. Dr. Canniff, medical health officer for Toronto, has also been sent as a delegate. The object of the meeting is to recommend to the governments of the United States and Canada the adoption of measures to prevent the invasion and spread of cholera, which is confidently expected to visit our shores next summer.

REMOVAL OF A CYSTIC KIDNEY.—Dr. McLean, Prof. of Surgery, Ann Arbor, Mich., (*Phys. & Surg.*) formerly of Kingston, Ont., removed the left kidney which was in a state of cystic degeneration, both ovaries and a portion of the greater omentum, on the 26th of October last, from a woman supposed to be pregnant (2nd or 3rd month). At last accounts, seventeen days after the operation, the patient was doing well.

EPIDEMIC OF SMALL-POX.—An epidemic of this loathsome disease has broken out in the county of Hastings. In the village of Stoco, scarcely a family has escaped the scourge. The secretary of the Ontario Board of Health, Dr. Bryce, has made a tour of inspection of the district, and is doing all in his power to prevent the spread of the disease.

VACANCIES IN U. S. ARMY AND NAVY.—The *Medical Record* of New York states that for several years there have been a number of vacancies in the United States army and navy medical department. There are not enough applicants to fill the situations. This ought not to be the case, inas-

much as the position is a very desirable one for a young man, and the salary is very good.

ANOTHER LOCAL ANÆSTHETIC.—Our attention has been drawn by Dr. Ryerson of this city to the anæsthetic powers of Rhigolene, a drug introduced to the profession some time since by Dr. H. J. Begelow, of Boston. Rhigolene is a naphtha obtained by re-distillation of petroleum. It is not a definite compound but is the most volatile liquid known and one which produces the greatest cold on evaporation. It is highly inflammable. Used in the form of a spray it freezes rapidly and *deeply*. Its effects are somewhat evanescent, but can be maintained by frequent sprayings. It seems likely that Rhigolene may play a prominent rôle in general surgery, inasmuch as the hydrochlorate of cocaine has been found to be a comparative failure when applied to the unbroken skin, and when injected hypodermically has produced unpleasant constitutional symptoms, with imperfect local results.

LIGATURE OF THE CAROTID AND JUGULAR VEIN.—Dr. Deakin (*Lancet*, Nov. 15th), has recently applied a ligature to the right common carotid artery, and two to the jugular vein, in the removal of an epithelial tumor of the neck. Although a cure could not be looked for in the case, the result of the operation was satisfactory.

AMYL NITRITE IN ASTHMA.—Dr. W. B. Richardson, of London (*Asclepiad*, July, 1884) gives the following formula for its administration: R. Amyl Nitrite, M. xxxv., Alcohol, ℥v., pure glycerine to ʒiiss,—M. One fluid drachm in a wineglassful of warm water.

SUCCESSFUL OVARIOTOMY.—Mr Knowsley Thornton has lost but three of his last one hundred ovariectomies. He is a follower of Lister. Of the three patients that died one had malignant disease and the others died of hemorrhage.

THE death of Dr. Henry Martin, of Boston, who has been for years identified with vaccination, is announced in our exchanges. His son will continue the business.

GLEET.—*Pinus canadensis* is a specific in gleet. Its action is prompt and permanent.

Books and Pamphlets.

A PRACTICAL TREATISE ON FRACTURES AND DISLOCATIONS, by Frank Hastings Hamilton, M.D., LL.D., late Prof. of Surgery in Bellevue Medical College and Surgeon to Bellevue Hospital, New York; St. Elizabeth Hospital, etc.; Author of a Treatise on Military Surgery and Hygiene, a Treatise on the Principles and Practice of Surgery, etc. 7th American edition, revised and improved. Illustrated with three hundred and seventy-nine wood cuts. Philadelphia: H. C. Lea's Son & Co. Toronto: Williamson & Co.

This most excellent and classic work of Prof. Hamilton has now been before the profession for a quarter of a century, and is well known to surgeons both at home and abroad. The present edition has been carefully revised and re-written, and new matter has been introduced, which adds to its value as a work of reference. The work now comprises about 1,000 pages octavo, and is noted alike for its originality and completeness. The author has taken nothing for granted, and commends no procedure for which he does not find a warrant in the results of his own experience. From the beginning of his studies, he declares, he has found one of his most difficult labors in attempting to eliminate from surgery the numerous "false facts" or unreliable statements derived from observations made on the cadaver or on cabinet specimens whose history is unknown. We unhesitatingly recommend the work to our readers.

THE SCIENCE AND ART OF SURGERY.—By John Eric Erichsen, F.R.S., LL.D., F.R.C.S.; Emeritus Prof. of Surgery in University College, etc. Eighth Edition. Revised and Edited by Marcus Beck, M.D., Land, F.R.C.S., Prof. of Clinical Surgery in University College, London. With 984 Engravings on Wood. Volume I. Large 8vo. Pp. 1124. Philadelphia: Henry C. Lea's Sons & Co. Price, \$5.50.

Each of the various editions of this magnificent work has been noticed by us from time to time. It is only necessary for us now to inform our readers in regard to the present edition, which the author has thoroughly revised in order to bring it abreast of the knowledge of modern surgery. Erichsen's surgery since its first publication, more than thirty years ago, has held a position second to no other work upon surgery as a text book or a work for reference both in England and in this

country. When it consisted of but one volume, its convenient size and completeness of detail commended it, in our estimation, as one of the most valuable texts books for students. Yet although enlarged and made into two volumes, it is so free from prolixity and tediousness that we have no hesitation in recommending it to the attention of students as well as the general practitioner.

THE NATIONAL DISPENSATORY, containing the Natural History, Chemistry, Pharmacy; Action and Uses of Medicines. By Alfred Stillé, M.D., LL.D., and John M. Maisch, Phar. D. Third Edition thoroughly revised, with numerous additions, with three hundred and eleven illustrations. Philadelphia: Henry C. Lea's Son & Co., Toronto: Williamson & Co.

This valuable work is already so well known to the profession in Canada and the United States as to require only a brief notice at our hands. Complete information will be found in regard to all remedies, both old and new. Even in the matter of the new local anæsthetic it contains the fullest information. The work is almost a necessity to every practitioner of medicine as a book of reference.

DISEASES OF THE EYE, by Henry R. Swanzy. New York: D. Appleton & Co. Toronto: Hart & Co.

This book, which is about the same size as Dixon on the eye, is intended for the use of students attending an ophthalmic hospital, but will also be found very useful as a convenient work of reference for practitioners. The work is largely a compilation from standard works. The author rarely putting forward his own opinion or practice very prominently. The work is well and appropriately illustrated, and the text well written. A very interesting chapter treats of the motions of the pupil in health and disease.

MANUAL OF CHEMISTRY by W. Simon. Philadelphia: Henry C. Lea's Son & Co. Toronto: Hart & Co.

This may be considered, in some respects at least, as a companion work to the foregoing. It is intended as a guide to a course of lectures on general chemistry, but will be found especially useful to pharmaceutical and medical students. The work treats of organic and inorganic chemistry, qualitative analysis, physiological chemistry, etc.

The work is well printed on good paper and clear legible type, and is well adapted to the use of the general student of chemistry.

PHYSIOLOGICAL AND PATHOLOGICAL CHEMISTRY, by T. Cranstoun Charles. Philadelphia: Henry C. Lea's Son & Co. Toronto: Willing & Co.

A knowledge of this branch of medicine is of great importance in the study of the science and art of medicine. Physiological chemistry promises much in the treatment of disease. The work before us gives an excellent outline of the most important branches of physiological chemistry, and in order to render the work more complete the author has given brief descriptions of such bodies as sugars, fats and certain salts. We commend the work to the attention of the student of chemistry.

THE PHYSICIAN'S VISITING LIST (Lindsay & Blakiston) FOR 1885. Thirty-fourth year of its publication. Philadelphia: P. Blakiston, Son & Co.

This popular List continues to maintain its former reputation. It was the pioneer in this line of publications, and fulfils every requirement of a daily companion. Every practising physician should have a visiting list; it will save him ten times its cost in the year.

THE MEDICAL RECORD VISITING LIST FOR 1885. New York: W. Wood & Co.

We have received a sample copy of this valuable and popular visiting list. In its preparation nothing has been omitted which is necessary in a pocket record. It is most concise, compact, and handsomely finished work, and will be found a most useful companion.

Births, Marriages and Deaths.

On the 10th of December, P. J. Strathy, M.D., M.R.C.S., Eng., to Fannie, youngest daughter of the late J. Alley, Esq., Toronto.

In Kingston, on the 29th of November, James McCammon, M.D., Mayor of Kingston, aged 51 years.

In Montreal, on the 12th of November, A. B. Craig, M.D., aged 60 years.

*** The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

THE CANADA LANCET.

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MEDICAL AND SURGICAL SCIENCE.

CRITICISM AND NEWS.

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Original Communications.

INTERNAL OBSTRUCTION OF THE BOWELS.

BY A. B. ATHERTON, M.D., L.R.C.P. & S. ED., TORONTO.

(Formerly of Fredericton, N.B.)

CASE I.—August 12th, 1883. G. L., male, æt. 25. Always healthy. Never laid up by illness in his life. Ate some green peas at yesterday noon, and a quantity of ham in the evening. Was seized with violent pain in the abdomen at 1 a.m. A free movement of the bowels took place at 3 a.m. Pain continued and vomiting then also began. 30 drops of laudanum were administered by a friend, but with little relief. Was visited by me at 8 a.m., when I gave $\frac{1}{3}$ gr. of morphine hypodermically. This kept the patient pretty easy till noon, when half an ounce of castor oil with 30 drops of laudanum were taken. At 5 p.m. the pain became so severe again that I repeated the morphine as before.

Aug. 13, 8.30 a.m.—Pain returned early this morning. Vomiting is frequent and copious, and no motion of the bowels has occurred since yesterday morning; morphine repeated, also half a drachm of spirits of turpentine in warm soap and water administered in the form of an enema; to be followed in half an hour, if no action of the bowels, by a quart of warm water. Turpentine stupes externally.

8 p.m.—Free vomiting during the day, though only 2 or 3 cups of tea have been swallowed. Vomited matters are of a sour taste and smell, and also very bitter. No flatus has passed per anum since the attack began; neither has any of the enemata come away. Pulse, 104; temp. in mouth, 99.8°. Little or no abdominal distension. Pain and tenderness are greatest in the epigastric region. Morphine repeated in the arm. Also

ordered a pill of $\frac{1}{3}$ gr. morphine and $\frac{1}{2}$ gr. of ext. belladonna, to be given pro re nata. To have only iced milk and lime water in small quantities.

Aug. 14, 10 a.m.—Rested pretty fairly till 3 a.m., when the pain and vomiting returned. Has taken 6 of the pills since that hour, but probably several of them were vomited. The amount of greenish sour fluid ejected is still large, though little ingesta is taken. The urine has been very scanty from the first. Pulse, 96; temp. 99.2°. Face looks somewhat pinched. Hypodermic injection of morphine repeated. To suck bits of ice and swallow little else.

12.30 p.m.—Comfortable since morning, and not much vomiting. About 3 quarts of warm water administered very slowly as an enema through a long tube. No great amount of force was required to inject it, but the patient complained of a good deal of pain at the last, and I then desisted. He then got up and passed about two quarts in gushes. Little or nothing came away in the water. Ordered a suppository containing $\frac{3}{4}$ gr. of morphine and 1 gr. of ext. of belladonna pro re nata to relieve pain.

8.30 p.m.—Vomiting continues. Used one suppository about half an hour ago. No further motion from the bowels. Abdomen seems to be growing flatter, especially from umbilicus downwards. Pulse, 108; temp. 99.5°.

Aug. 15, 9 a.m.—Rested fairly well without any more opiate. Vomiting not quite so frequent, but the fluid thrown up has an intestinal odor. Had some hiccough during the night. Feels less pain; no improvement in facial expression. Pulse 96, small and compressible; temp. in mouth, 97.5°; in rectum, 99°.

11 a.m.—Dr. Coburn, of Fredericton, saw the patient with me, and agreed in the opinion that there must be some intestinal obstruction. As, however, he had been rather freer from pain and vomiting, and some flatus had passed per anum. for the first time this morning, it was deemed advisable to wait a few hours before operating. Pulse, 120; temp. in mouth, 99.8°; in rectum, 101°. Extremities rather cool.

8 p.m.—Vomiting of intestinal—smelling matter continues. Pulse 128, feeble; temp. as before. Mind has wandered at times during the day.

Operation (by lamplight).—Chloroform, followed by ether. Assisted by Dr. Coburn, and Messrs.

Owens and Sury, my medical students. The anæsthetics were taken badly. The catheter was passed but no urine found. A longitudinal incision was made, commencing to the left of the umbilicus and extending down about four inches. On cutting through the peritoneum, congested small intestine presented itself. On examination two loops were found connected closely together by a very short band of adhesion, which dragged upon one part so as to constrict very considerably the gut. I could scarcely insert the tip of the finger beneath this band and adjoining loops of bowel. A catgut ligature was thrown around the adhesion and tied. There was no room for a second one, and I therefore divided the band with the scissors. No bleeding followed. As only a few inches of the intestine seen was much distended, there was no protrusion; and I readily brought the abdominal wound together with deep silver sutures and superficial catgut ones. Carbolic spray and other antiseptic precautions were used throughout.

10.30 p.m.—The patient has been very restless and pugnacious since coming out of the ether, and it was with difficulty he could be kept in bed. Has swallowed a few teaspoonfuls of iced milk, and has had an ounce of brandy in a cup of warm milk and water by enema. No vomiting since the operation, and flatus has passed several times per anum. Extremities are pretty cold. Pulse 132, very feeble. Hot irons put to feet. $\frac{1}{4}$ gr. morphine subcutaneously, to help keep the patient quiet.

Aug. 16, 8.30 a.m.—Slept 4 or 5 hours altogether during the night. Took some brandy and milk by the mouth, and had an enema of the same at 3 a.m. No vomiting; no motion of the bowels. Wildly delirious at times. Extremities cold. Little or no pulsation at wrists. He died at 10.30 a.m.

Autopsy 11 a.m.—The point at which the ligature was applied was found to be only 4 feet from the pyloric end of the stomach. A considerable thickening of the peritoneal coat ran in a somewhat band-like form around the gut from the ligatured adhesion. Along this line the bowel presented somewhat of a wet leather appearance, but there was no ulceration of the mucous coat at the part, and the calibre of the intestine was not very greatly diminished either here or elsewhere. Stomach and upper 4 feet of bowel dilated; be-

low this the latter was empty and contracted. Two of the mesenteric glands were calcareous.

CASE II.—Oct. 19, 1883.—A. J.'s child, æt. 11 months, female. A few weeks ago the child had measles, which was followed by a serious attack of bronchitis. Two or three days since the patient began to suffer from vomiting and diarrhœa, but was not ill enough for a physician to be sent for. At 2.30 a.m. the patient awoke with pain and vomiting, and the passage of a thin, bloody fluid from the bowels. Was visited by me at 5 a.m. I gave at once 6 or 7 drops of tinct. opii in a little warm water as an enema, and ordered her to have 2 drops of the same by the mouth *pro re nata*, also to take only one teaspoonful of barley water every half hour. The distress seemed very great when the patient vomited, and the fluid ejected resembled very much the rice water which she had been drinking during the night.

11 a.m.—Has required one or two doses of the laudanum, and has been much easier. No further vomiting, though there has been a little retching. Two bloody discharges. Continue opiate as before, and two teaspoonfuls of barley water at a time.

8 p.m.—Vomiting has come on again, and the bloody dejections have been more frequent. Pulse, 160; temp. beneath arm, 101°. Rather pale and collapsed-looking. On examination per rectum, no tumor felt, though anus seemed more patulous than usual. No great abdominal distension, and no marked tenderness on palpation. On deep pressure a cylindrical tumor was found lying just to the left of the median line, and extending from the pubes upwards to the side of the umbilicus, being about $3\frac{1}{2}$ inches in length and $1\frac{3}{4}$ inches broad. Resonance not quite so good over the swelling, but no marked dulness present. I now wrapped a piece of rag about the base of the nozzle of a Davidson's syringe, so as to form a plug for the anus; and, holding the instrument tightly against the fundament, I injected slowly a pint or more of warm water, while at the same time I manipulated the tumor through the abdominal walls. During this procedure the swelling appeared to move somewhat towards the right and disappear. I now allowed the water to escape, and examined the abdomen again. No swelling felt above pubes, but as I imagined there was an abnormal fulness and hardness in the right hypo-

chondriac and epigastric regions, I repeated the enema with the head and shoulders lowered. During the administration of the last of the enema, about six ounces of greenish fluid burst from the mouth, and I then allowed the water to escape per anum. No fæcal matter, mucus, nor blood came away with either enema.

10 p.m.—Has rested well since enemata. No vomiting, and no movement of the bowels since visit. No tumor felt. Pulse, 145.

Oct. 20, 9 a.m.—Doing well; pulse, 136. Countenance improved. 9 p.m.—No vomiting since the disappearance of the tumor. Has had two or three greenish motions to-day. No blood.

Oct. 21.—Appears almost well. Takes the breast and vomits nothing.

REMARKS.—That a distended abdomen is not necessarily present in all cases of internal obstruction is quite evident from the first case reported above. The belly was really *retracted* in that instance, which was of course due to the seat of trouble being so close to the stomach, thereby leaving only a few feet of intestine above to be dilated, the portion below becoming empty and contracted as is usual. It would undoubtedly have afforded this patient a much better chance for life if laparotomy had been done earlier; but one is apt to hesitate and delay about resorting to so serious an operation, that the latter is often not undertaken until symptoms of collapse, or general peritonitis, or gangrene supervene, and then the patient succumbs. I intended to have performed the operation on the morning of January 15th. had there not occurred a passage of flatus downwards for the first time, which led me to hope that the obstruction was about to yield. Besides, it will be observed that the abdominal section was made before the end of the 4th day, and as I had previously operated on two cases* of internal strangulation at the end of the 5th and 6th day respectively—the former of which recovered, and the latter lived till the 7th day after the operation—I thought I could afford to wait a little. But it is quite clear that the *length of time* that has elapsed cannot be relied upon entirely as a guide to the condition of the bowel, and consequent urgency for surgical interference, any more in cases of internal obstruction than in those of strangulated hernia, and one

must evidently be largely governed as to the advisability of immediate operation by the degree of the acuteness as well as the severity of the symptoms attending the attack.

As to the character of the second case reported, I think there can be little room for doubt. The acuteness of the symptoms, the vomiting, the passage of the thin, bloody serous discharges, the presence of the sausage-like tumor, and the speedy and complete relief obtained by the use of the large enemata, all combine to prove the existence of an intussusception. The patulous condition of the anus, I think, is also mentioned by some as likely to be found in such cases. I did not give an anæsthetic before administering the enemata, because I did not suppose there would be much muscular resistance offered to prevent the reduction of the bowel in a subject so young, and in one who was so much prostrated by the disease. The readiness with which that object was attained is sufficient evidence that the assistance of such was not required.

THORACO-PLASTIC OPERATION OF ESTLANDER.*

BY J. FULTON, M.D., M.R.C.S., ENG., L.R.C.P., LON.

Prof. of Surgery and Clinical Surgery, in Trinity Medical College, Toronto; Surgery to the Toronto General Hospital; Author of Text-Book of Physiology.

GENTLEMEN,—It is not possible for me, within the time assigned, to discuss satisfactorily the pathology, or even the clinical history of empyema, although the disease is one of the most interesting which the surgeon is called upon to treat. I shall, therefore, confine myself entirely to the treatment of the chronic form of the disease by what is known as Estlander's operation. I also desire to draw the attention of the profession to this operation which, so far as I know, has rarely been performed in America the first reported case being given by Dr. Fenger, of Chicago, in the *Medical News* for Sept. 1882.

The resection of a portion of a rib for the more thorough evacuation of pus, and for the application of remedies to the cavity of the pleura, has long been practiced; but the object which Estlander had in view in his operation, was the obliteration of the suppurating cavity and occlusion of the per-

* Reported in Boston *Med. and Surg. Journal* of June, 1883.

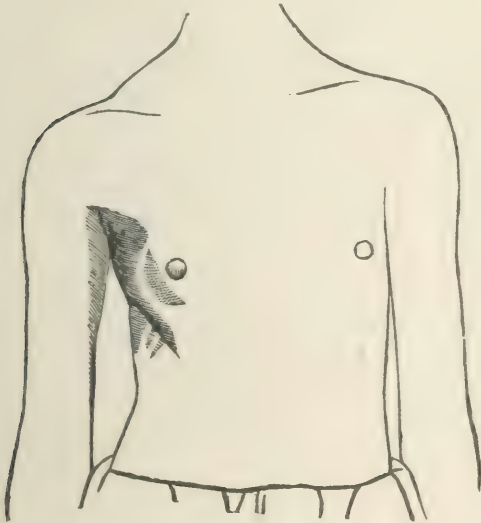
*Read before the Canada Med. Association, August, 1884.

manent pleural fistulæ which are consecutive to the incision in empyema. I need scarcely say that nearly all intelligent surgeons of the present day treat cases of empyema, especially in the adult, by free incision and drainage, together with thorough washing out and disinfection of the cavity. The results of this method of treatment are, upon the whole, satisfactory. Dr. Homen, in an interesting paper in (*Archiv fur Klin, Chirurg, Langenbeck's Journal*), gives the statistics of 52 cases of empyema, treated by free incision, drainage and disinfection. Of these fifty per cent. recovered, thirty-three per cent. died, and in seventeen per cent. permanent fistulæ remained. This may be considered a fair statement of the average results obtained in general practice. The pleural fistula is in most cases, the result of the formation or existence of a cavity between the thorax and the lung, lined by soft pus-secreting tissue. This is much more likely to occur where the opening for the evacuation of pus has been made late in the disease, and where the expansive power of the lung has been impaired by the long continued pressure. The size of such a cavity, and the amount of pus discharged from the opening may vary very much, but even a moderate amount of discharge is not only a great inconvenience to the patient, but also a source of danger, by so depleting the system as to lay the foundation of amyloid degeneration of the kidney, spleen and liver, or tuberculosis. In view of these facts, it is clearly the duty of the surgeon to adopt every possible means in order to effect the closure of the cavity. In such cases Estlander's operation seems well calculated to secure the end desired. It consists in the removal of a portion of the chest wall, in order to produce a certain degree of sinking in, and allow the parietal and visceral layers of the pleura (or chest-walls and lung) to come into contact. Before proceeding to discuss the operation, its indications and contra-indications, and the after-treatment, I will report the following case occurring in my practice in the Toronto General Hospital :—

Mary B—æ 28 years, was admitted into the Hospital on the 6th of November, 1883. Parents living, family history good; has had no illness since childhood, except the present, which took place on the 28th of April, 1882, from an attack of pleurisy. She was treated by Dr. Smith, of Walkerton, who discovered fluid in the pleural cavity of

the right side on the 30th. He aspirated the chest twice during the months of May and June, removing large quantities of serous fluid. On the 8th of July, 1882, when the aspirator was again used, pus was discovered. The chest was then opened by incision and washed out daily from that time until July, 1883, when a second operation was performed in order to enlarge the opening in the chest which had nearly closed. In the latter part of August, 1883, she came under the care of Dr. Stalker, of Walkerton. He continued the treatment by washing out the cavity with a solution of salicylic acid, as carbolic acid had, on a previous occasion, produced symptoms of poisoning. From the time the first incision was made, July 1882, until the date of her admission into the Hospital, there was no appreciable change in her condition or the amount of the discharge. On admission the patient was spare and anæmic, but not extremely emaciated; appetite poor; slight hectic. The right side of the chest was sunken and flattened, causing a certain amount of lateral curvature of the spine and lowering of the right shoulder. In the axillary line, and between the sixth and seventh ribs was the opening in which a rubber tube was inserted. The amount of discharge was from two to four tablespoonfuls daily. In the upper part of the right side the percussion note was clear, but dull in the lower portion. Vesicular respiration was weak throughout, and almost indistinct in the lower part. The left lung was normal, pulse 90, temperature from 99 to 100: bowels regular, urine healthy. In the meantime the cavity was washed out daily with carbolic lotion 1 to 60, to which tincture of iodine was added. But as no improvement followed, on the 30th of November, in the presence of the members of the Hospital staff and medical students, I performed Estlander's operation. Ether was administered and the patient placed upon her left side. An incision about five inches in length was made between, and parallel to, the sixth and seventh ribs. The lower margin of the incision was drawn downwards by means of retractors, so as to expose the seventh rib. The periosteum was divided longitudinally in the median line of the rib, raised on each side, and a portion of the rib three inches long removed by means of a bone cutting forceps. The upper margin of the wound was then drawn upwards and a corresponding portion of the sixth rib removed in the same way. The pleura costalis which was much thickened, was not disturbed

except to make a larger opening by the introduction of the finger, for the insertion of a large-sized drainage tube. There was very slight hemorrhage during the operation, which was arrested by torsion no ligatures being required. The cavity was then thoroughly washed out with carbolic acid solution, a large drainage tube inserted, the wound sutured and dressed with marine tow. There was very little shock. At 6 p. m. pulse, 120; temperature, $99\frac{1}{2}$; the patient felt comfortable with the exception of pain in the wound which was relieved by opiates. Without detaining you by recounting the daily history, I may say that her progress was quite satisfactory, with the exception of a rise in pulse and temperature on the third day which was readily controlled by five grain doses of quinine every four hours. The cavity was washed out daily with solution of carbolic acid, to which tincture of iodine was added; the discharge gradually diminished, and the patient's general health rapidly improved, so that she was able to leave the Hospital early in March, 1884. I have just received a letter from her former medical attendant, Dr. Stalker, in which he says, that she is greatly improved in her general health. He did not enquire as to her increase in weight since her return from Toronto, but it must



be considerable. The cavity is gradually becoming closed up, and he says he feels satisfied that in the course of a month the drainage tube now in use may be discarded, and the wound allowed to heal." Before she left the Hospital there was considerable sinking in of the chest, most marked

opposite the sixth and seventh ribs, as shown in the diagram.

The ends of the resected ribs could be distinctly felt, but the tissue between had become more or less firm, showing an attempt at reformation of bone. The patient's general condition was much improved; her appetite was better, and her anæmia had almost entirely disappeared. The report above referred to shows that this improvement has continued, and that she is now almost entirely well.

With regard to the indications for the operation it may be stated in general terms, that in all chronic cases of empyema which have resisted ordinary treatment for a lengthened period, the operation should be resorted to. It is, of course, impossible to fix a stated period, that will apply to all cases; but when a fistula has existed from six to eight months without any sign of improvement, such as diminution in the size of the cavity, or the amount of the discharge, disappearance of hectic, or improvement in the patient's general condition, this procedure should be put in practice, provided there are no contra-indications, such as advanced tuberculosis, albuminuria, or extreme emaciation. The size of the cavity may be easily determined by passing a long probe or catheter through the fistula. Estlander has shown that "even in cases of extreme debility, patients being so weak as to be scarcely able to turn in bed, the operation caused very slight derangement of the system, and was followed immediately by marked improvement. It is scarcely necessary to say that if albuminuria be present from amyloid kidney, the patient is liable to succumb to very slight shock. The operation is by no means a trying one, and may be safely resorted to in very delicate subjects."

With reference to the operation itself, the position, size and direction of the incision will depend upon the situation of the cavity and the fistulous opening. The most favorable position is upon the lateral portion of the thorax in the axillary line, the intercostal spaces being there covered by the serrations of the serratus magnus. The length of the incision and portions of ribs to be removed will depend upon the size of the cavity in the horizontal direction. For the excision of portions of two or three ribs, one single incision parallel to, and either between the two or over the middle rib of the three to be removed, will be quite sufficient. If a greater number are to be excised, parallel

incisions may be made above or below as required. The number of ribs to be removed will be determined by the dimensions of the cavity in the vertical direction. The surgeon need not hesitate to remove portions of three, four, five, or even six ribs. For obvious reasons the first and second, and the eleventh and twelfth are never interfered with. The periosteum should first be divided longitudinally along the middle of the rib, and raised from the latter before removing it. The pleura should not be interfered with, except so far as necessary to enlarge the fistulous opening, or to make a new one in the most dependent position to secure proper drainage. There is usually very little hemorrhage. After the operation the cavity should be thoroughly irrigated so as to remove any blood which may have entered during the operation. The wound should be united, drained and dressing applied. In the after-treatment in addition to the constitutional remedies which may be indicated, such as quinine, iron, codliver oil, etc., the cavity should be regularly washed out with disinfectant solutions, and the healing process may be further facilitated by the occasional use of stimulating lotions containing tincture of iodine, sulphate of zinc, etc. A favorite plan in my own practice, is to add two or three drachms of tincture of iodine to the carbolic lotion to be used for washing out the cavity. When it is found the progress of the case comes to a stand-still, which may be determined by the repeated use of the probe or by frequent measurement of the quantity of fluid injected the operation may be repeated. Occasionally great assistance in closing the cavity may be derived by the application of an elastic bandage around the chest. In conclusion I would say that Estlander's operation may be regarded as a valuable procedure in the treatment of chronic empyema, and that useful lives may be saved by the operation.

ANGULAR CURVATURE OF THE SPINE OF OVER TWO YEARS' STANDING.— RECOVERY.*

BY J. CAMPBELL, M.D., L.R.C.P., E., SEAFORTH, ONT.

Mrs. B., æt. 33, a native of England, married, mother of one child, consulted me and gave me the following history. Over two years ago she felt

* Read before the Huron Med. Association, 8th July, 1884.

pain and weakness in the back while washing. "Went to a medical man and told him my trouble, and drew his attention to a small lump on my back. He did not strip my body nor examine it, but told me I would never get better. Took medicine for two years from him and during this time the lump was becoming larger and the pain more severe. Had to lie in bed the greater part of the day and could do no work." Before coming to my office she had pains shooting down the legs and was harrassed by an irritative fever. On Sept. 2nd, 1883, she came to my office and appeared to be wretched enough. From her walk I suspected Potts' curvature at once. She had a pulse of 120, with a temperature of $101\frac{1}{2}^{\circ}$, with a careworn anxious countenance, indicative of pain. She told me that the shaking of the buggy gave her pain and that her husband had to make the horse walk the most of the way, a distance of 18 miles. Her tongue was furred and appetite gone, hence she felt pretty weak. Stripped the body and examined the spine particularly, and found displacement three inches in length and one in depth, involving the last dorsal and first and second lumbar vertebrae. I told her that the only hope of cure was in the application of Sayre's plaster of Paris jacket, or otherwise in lying still in bed day and night, and in supporting treatment, cod liver oil, hypophosphites, etc. She chose the jacket, and accordingly on the same day, with the assistance of Dr. Scott, of Seaforth, we put on Sayre's jacket, suspending her in the usual way. She said she felt complete relief from pain, and that she could jump off the doorstep of the house immediately. After the plaster hardened I put her upon syru of fer. iod. with cod liver oil and hypophosphites, advised good unstimulating nourishment and abundance of fresh air. The first jacket was kept on six weeks. She was free from pain until the jacket began to get loose, then pain returned again. Had the second jacket put on and felt relieved as before. Kept it on six weeks also; improving steadily. She took the medicine as before. During all this time she was able to ride around in a buggy, what she had not been able to do before, as every jar gave her pain. At the end of the six weeks we put on another jacket. She did not get the same relief from this one; whether it was our fault or not, could not say. She came back at the end of one week and had another put on, which proved more suc-

cessful, as she had complete relief from this one, and kept it on four months. During all this time she was getting stronger and was free from pain. The displacement never increased after the first jacket was put on. She came back at the end of four months and we put on the fifth jacket, which was on over three months with good results. She began working and felt pretty well. We now put on the sixth jacket, and did not see her again for ten months, but had a note from her husband stating that she was doing well. After wearing this jacket two and a half months she slit it up as we had previously directed, and laced it up in front like corsets. This enabled her to wash her body and keep herself clean. She continued taking the medicine and cod-liver oil, as previously mentioned, and improved all the time. She has gained fifteen pounds in weight, is cheerful, has no pain, and does all her own work. She came back on the fifth of June last for the purpose of getting us to put on the seventh jacket which we did. After a particular examination we arrived at the conclusion that consolidation had taken place. There was no pain nor tenderness on pressure or percussion over the displaced vertebræ, nor any other bad symptoms. She wished to have the jacket put on, she said, because she felt more comfortable with it than without it. It looked to her like an old friend, and she did not wish to part with it. The cure may be considered complete, and it is not likely that another jacket will be required or asked for even for friendship's sake. In fact we did not think the last was required, but put it on at her own request as we knew it could do no harm, and it is always better to err on the safe side at any rate.

Remarks.—My reasons for reporting this case are the following :—1st. I had a conversation with an old pupil of Dr. Stewart, of Brucefield (who introduced Sayre's jacket into this county, and who probably put on more jackets than all the doctors in it), and this gentleman said that he never yet knew of a cure from it, and he only knew of one case that was benefited by it. Now, I thought, if that be true, I must report my case, which is undoubtedly a complete cure. 2nd. When we consider the age of my patient, namely, 33 years, the cure is the more remarkable, as I believe it is conceded that the older the patient the less chance there is of receiving benefit, and that after twenty

years of age the prognosis is rather grave. 3rd. My patient was over two years ailing before I saw her. The disease was very pronounced, as this report shows, and the woman in a miserable condition, all of which things were against us, for all will agree that the sooner a case of this kind is diagnosed and treated the better. 4th. The relief was instant, which in itself was worth a great deal, even if she had not recovered, and the improvement, though gradual, continuous, until the consummation so devoutly to be wished was finally arrived at.

CARBOLIC ACID IN PURULENT AFFECTIONS OF THE CONJUNCTIVA AND CORNEA.*

BY G. HERBERT BURNHAM, M. B., F. R. C. S. EDIN.,
M. R. C. S., ENG., TORONTO.

Late Resident Surgeon to Moorfield's Eye Hospital, London.

A few years ago when Resident Surgeon to the Moorfield's Eye Hospital, London, I introduced into ocular practice the use of the 5 per cent. lotion of carbolic acid in gonorrhœal ophthalmia. Previous to this I had tried every variety of treatment then recommended with a success not very encouraging.

The deep transparent excavations of the cornea so frequent in this affection, so often followed by perforation and prolapse of the iris, or deeply infiltrated ulcers which, through leaking in their floor, give rise to falling forwards and adhesion of the iris to the posterior surface of the cornea not again to be loosened; or other cases in which the ulceration rapidly involved the whole cornea, causing destruction of vision, and at times of the eye itself—all these terminations have I at different times witnessed and seemed powerless to prevent. If the changes did not go so far, still I have been kept on the wings of expectation, not knowing, with the arsenal of remedies then at my command, what the outcome might be. These are a few of the considerations which made me anxious to get a better and more reliable remedy. Now, after a considerable lapse of time, I feel that I have secured the desired remedial measure in carbolic acid. I have tested its merits in all the various forms of gonorrhœal ophthalmia, for instance, in

* Read before the Ontario Medical Association, June, '84.

that with much serous chemosis and swelling of the ocular and palpebral conjunctivæ; in that where the œdema is as great, but harder and denser; in that where the conjunctivæ of eyeball and eyelids and the sub-conjunctival tissue, are so fully loaded with exudation as to give the brawny, mottled look of diphtheritic ophthalmia. In fact, quite lately, I had a case, that of a young man, in whom the inflammation was the most violent I ever witnessed. The partly everted lids had the mottled, white and red look with inability to remove any of the infiltrations so characteristic of diphtheritic ophthalmia. When the tissues began to unload themselves, quite large pieces came away leaving excavated and bleeding surfaces. I value the treatment by carbolic acid so much above all the other varieties that I have ever employed, that I now use no other. Under its influence, the transparent excavations quickly heal, and, moreover, have never, since I began its use, progressed to perforation, as formerly so often the case. The same may be said with respect to the other forms of corneal ulceration brought to our notice in gonorrhœal ophthalmia.

I, however, met with one form of corneal mischief, which I do dread, and against which I am not as well provided, as I could wish. This form is the deep, circumscribed infiltration of the cornea with the external surface unabraded. Here the morbid process goes on extending inwards till hypopyon comes. After this the external surface ulcerates, and then the part is so weak, that at once perforation of the cornea and entanglement of the iris, more or less complete, take place. The powerlessness of carbolic acid in this variety is due to its inability to reach the seat of mischief. The consequences of these cases being such as I have mentioned, have determined me to do *Saemisch's* operation when the opportunity is given me, and by so doing bring the abscess under the benign influence of this acid. This action I shall take though well aware of the great danger of incising the cornea in the midst of such a fierce purulent discharge. As is well-known in the worst forms of gonorrhœal ophthalmia the lids are so swollen and stiff, that only very partial or no eversion can be made. This prevents the proper application of other forms of treatment, such as strong solutions of nitrate of silver, the mitigated and pure stick. The carbolic acid lotion travels with great ease

beneath the lids, and hunts out as it were all the obscure places. The way in which to make such a thorough application can, after a short time, be taught any moderately skilful nurse. These last truths I consider of great moment, and factors telling much in its favor.

The course pursued in the treatment of a case of gonorrhœal ophthalmia is as follows: The patient is ordered to bed; then there is placed at his bedside a large basin of cold water in which there is always kept a big piece of ice. The eye is to be bathed by the patient, or by the nurse, very frequently so as well to cleanse the eye. In the intervals cloths wet in the iced water are constantly to lie upon the closed eyelids. The lotion of a strength 1 in 20, is to be thoroughly applied *every hour*, the lids being as well everted as possible. I always apply the lotion very freely, and at the same time tell the patient to move the eyeball about, so as to give the lotion as free access as possible. These applications are to be made day and night. In consequence of this a nurse must be in constant attendance. The pain and smarting, which ensues after using the carbolic acid, last but a few seconds, and are succeeded by a feeling of comfort and relief. This is another point in its favor, and in direct contrast with the effects of the powerful caustics heretofore employed. As the discharge becomes thinner and more laudable, the 5 per cent. lotion is to be used every second hour, and during the intervening hour, the 2½ per cent., or 1 in 40, is to be applied. As the virulence of the affection goes on diminishing, the 1 in 40 may be used altogether. I do not employ the watch glass protector, the ingenious contrivance of Dr. Buller, of Montreal, for the sound eye. I tell the patient to lie on the side on which the affected eye is, and warn him of the danger of inoculation. I consider these measures to be sufficient precautions when using so frequently an application of such strong antiseptic properties. I look upon this lotion as the most effective and reliable remedy we have at our command in gonorrhœal ophthalmia; and the more I make use of it, the greater becomes my faith in its power for good. The great *antiseptic* and *astringent* properties of carbolic acid place it, in my opinion, without a rival in the treatment of this inflammation.

This is its history in my hands with regard to the foregoing affection. I shall now mention it

with respect to other purulent affections, especially where the cornea is markedly implicated. One of the most dreaded sequels to a cataract extraction is purulent infiltration of the corneal wound. When this infiltration of the cornea has made its way to *Descemet's* membrane, and is also spreading in other directions in the corneal substance, and is associated with free purulent discharge, there is a feeling in the mind of the operator that the eye is as good as lost. It is in just such cases that I have more than once been completely successful, and have secured an unimpaired eye. I well recollect one case, that of an old and feeble man, an inmate of Moorfield's Eye Hospital, in whose eye on the third day after the operation, when union had taken place, infiltration of the wound set in. This, under the usual mode of treatment in such cases, got worse and worse. The infiltration alarmingly increased in depth and width, and the discharge became markedly purulent and copious. It was quite evident that improvement must quickly take place, or the eye would be lost. I now vigorously applied the 5 per cent. carbolic acid lotion. The result was that in two days the eye was out of all danger. Then, on examining the wound, there was to be seen a deep, broad excavation reaching to *Descemet's* membrane, with a ragged but healthy surface. The surrounding cornea was bright and clear. This excavation gradually filled up, and the patient went out with a good, serviceable eye. In those cases of kerato-iritis, where the corneal ulceration is extensive, this lotion has been used with most beneficial results. Here it is combined with the usual treatment of atropine, warm bathing and constitutional remedies. I have based all my remarks upon those cases in which the corneal inflammation was extensive, and associated with more or less purulent discharge, and where a new departure in treatment would show its usefulness, and enable a just conclusion to be drawn, in other words in test cases. If I think a weaker lotion than the 5 per cent. will answer the purpose, I may not at any time use the 5 per cent.

I feel that I am fully justified in strongly recommending the carbolic acid lotion in the various and kindred affections laid before you; for it has so often come out victorious in real test cases, and where previously non-success had too often been my lot. It is very necessary to use the *pure* carbolic acid, as any impurities give rise to such irritation and sometimes pain, as not only seriously to interfere with its full and proper application, but also materially to lessen its curative properties.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—Since reading an article in the December No. of the LANCET under the caption of "Professional Advertising," anent "our confreres down by the sea," I felt constrained to bring the following case of unprofessional conduct under the notice of the profession. Dr. A. is attending Mrs. S.; Dr. B., passing by, interviews Mr. S., and gains admission to the patient by the consent of the husband and without the knowledge of Dr. A. Dr. B. (by force of habit perhaps) finds fault with the diagnosis and treatment of Dr. A., and by fair promises gains the confidence of the patient, and takes the case. Dr. A. visits his patient next day, is astonished at the conduct of Dr. B., and leaves in disgust.

This individual is also in the constant habit of visiting the patients of other medical men in their absence and without their knowledge, and attempts to justify himself in some cases on the flimsy pretext that he was requested to do so by the friends of the patient. He also habitually volunteers his advice and opinions concerning the patients of other physicians solely upon "hearsay" evidence. When called in consultation it is his custom, when opportunity presents, to remain behind and converse with the relatives of the patient after the attending physician has retired, and by innuendoes and insinuations infer that the case has not been properly treated, though no such inference was made in the presence of the attending physician. This conduct is of frequent occurrence in the practice of an old established physician here, who, to keep the vituperations and slanders against other medical men fresh before the public, is generally accompanied by his helpmeet.

Your, etc.,

A RESIDENT PHYSICIAN.

Cornwallis, N.S.

Reports of Societies.

SAUGEEN AND BROCK MEDICAL ASSOCIATION.

A meeting of the Territorial Association of the Saugeen and Brock Division was held in the town of Harriston, on the 8th day of January, 1885. The following resolutions were carried:

That all the proposed amendments to the Medical

Act, except clause 4, meet with our approval, and that instead of appointing a taxing officer, this meeting recommends the adoption of a uniform tariff for the whole Province, legalized by the Medical Council, signified by the Seal of the College, and the signature of the President, as provided in Section XVI. of the Ontario Medical Act.

That all Medical Students, after the year 1887, shall be required to matriculate and attend a course of at least two full sessions in the Arts department of some University recognized by the Medical Council.

That the members of this Divisional Association, now assembled, desire to express their approval of the course pursued by the Medical Council, and also of their present representative, Dr. Douglas, during the past five years.

Referring to the tariff lately issued by the Grand Trunk Railway, as regards medical attendance upon their employees and passengers: That the medical tariff rates issued by the Grand Trunk Railway be disapproved of, and that we recommend that no medical practitioner in this Division do sign it.

(Signed)

R. DOUGLAS,

Chairman.

LLEWELLYN BROCK,

Secy. Treas.

Selected Articles.

THE METHOD OF EXAMINING ABDOMINAL GROWTHS.

The following clinic by J. Ewing Mears, M. D., Jefferson Medical College, reported in the *Med. News*, will be read with interest:

The presence of this patient to-day affords me the opportunity of speaking to you with regard to the methods to be pursued in the examination of patients suffering from abdominal growths. Having the patient prepared in this way and placed on her back on the table, the first step in the examination is inspection.

Inspection: The surface of the abdomen is inspected in order to ascertain whether it is uniform in shape. Its contour is observed and any enlargements or projections are to be noted. In practising inspection we should note not only any irregularities of the surface, but also the condition of the integument and any marks which may be found in the integument. For instance, your at-

tention is called to a line which frequently exists between the umbilicus and the pubes. Formerly this line, which has a brownish color, was regarded as diagnostic of pregnancy, it being usually found, or almost as a rule, in women who are pregnant. This line is also observed in the patient before you and I have seen it in a number of cases of abdominal tumors. It is, therefore, not pathognomonic of pregnancy, but it also exists in other cases of enlargement of the abdomen. This line is due to a pigmentary deposit, and, so far as I can recollect, I have never seen any satisfactory explanation why it should exist. In a recent case of ovariectomy not only did this line exist prominently between the umbilicus and the pubes, but brownish spots were also found on different parts of the body, face, chest, and right side of the surface of the abdomen and on the lower extremities. In this case the patient stated that the brown line and spots appeared after the development of the growth. Further, after pregnancy to full term has occurred, the surface of the abdomen may be marked by cicatrices, which indicate undue stretching of the integument. I call attention to this point, since it has happened in cases which have been presented at the clinic, that pregnancy has occurred in unmarried females and the history of the case has been entirely opposed to any such condition.

Having learned all that we can from inspection, the next step in the examination is palpation.

Palpation: By palpation we mean pressure with one, two, or three fingers upon the abdomen, carrying this, if necessary, to some depth. In order to facilitate this manipulation, it is desirable that the patient should be directed to inspire and then make a forcible expiration. By this means the diaphragm is drawn up and the walls of the abdomen are relaxed and deep palpation can then be made. By means of palpation we ascertain whether the cavity of the abdomen or the cavity of the pelvis is occupied by a growth, and, further, whether the growth is hard, soft, or elastic.

Percussion: The next step is to percuss the abdomen. Percussion is familiar to you all as one of the methods employed in the examination of the thoracic cavity. Beginning in the median line, we percuss downward from the ensiform cartilage to the umbilicus and pubes. The patient is then turned on her left side and percussion made over the right lumbar region. She is afterwards turned on the right side and the left side percussed in a similar way. Percussion gives us an idea in regard to the character of any growth in the cavity of the abdomen. The percussion note obtained over the intestine is resonant, or even more than resonant, tympanitic in character. Over a solid tumor the percussion note would be dull or flat. Over a cyst containing fluid it would also be dull or flat. By percussion, therefore, we determine whether the abdominal cavity contains anything more than the

intestines, which emit a resonant or tympanitic sound on percussion, and the extent to which the growth occupies the cavity.

Auscultation: Auscultation is also to be employed in the examination of abdominal growths. In carrying out this procedure it is necessary to apply the ear to different parts of the surface of the abdomen. If there is any reason to suspect pregnancy, the ear should be first applied over the left side of the abdomen, midway between the umbilicus and the middle of Poupart's ligament. At this point the foetal heart sounds can usually be heard, if the embryo occupies what is considered its normal position, that is, with the vertex to the left. Auscultation also enables us to determine whether or not the swelling which is present is due to aneurism, for by this means the presence of the aneurismal bruit can be determined.

The effort to determine *fluctuation* is the next step in the examination. By this is meant the production of a wave through the mass of fluid when the walls of the abdomen are struck or percussed. If one hand is placed on one side of the abdomen, and the other side is percussed with one or two fingers of the other hand, the movement of the fluid is felt distinctly. This wave differs much in amplitude according to the density of the fluid and also according to the character of the cyst in which it may be contained. If the fluid is thin and limpid, the wave is long; if the fluid is very dense and viscid, the wave is short. The ability to determine these differences is acquired largely by experience. I simply give you here general statements in regard to the differences in the fluctuation wave in fluids of different density. Fluctuation also enables us to a certain extent to determine whether the fluid is contained within a cyst or in the general peritoneal cavity. This also requires some experience in order to insure accuracy. Fluid in the general peritoneal cavity gives in fluctuation a wave which pervades the entire cavity, and this can be felt by placing the hand on different parts of the surface. When, on the other hand, there is even a thin cyst wall it is sometimes possible to distinguish the limit of the wave movement. Fluctuation can also be developed by introducing a finger into the vagina, and if the cyst occupies the pelvic cavity, fluctuation can be obtained by percussing the abdominal wall and feeling the wave with the finger in the cavity of the vagina.

I desire also to call your attention to a wave-like movement which is sometimes obtained on percussing the abdomen, and which is known as the fat wave. This wave is found in patients with very fat abdominal walls, this fat being loosely held in the meshes of the fascia. It is important that this be borne in mind, for errors in diagnosis have been made by the confusion of this wave with that of fluctuation.

We have so far examined the abdominal surface. It has been examined with the eye so as to determine its contour and outline. It has also been examined by palpation and percussion. The ear has been placed on the surface and auscultation has been performed. The effort has also been made to determine whether the fluid is contained within the peritoneal cavity or in a cyst in the cavity. This has been done by eliciting the fluctuation wave.

I might say, in addition, that it is desirable to employ mensuration—that is, measuring the enlargement. This can be done by a tape-measure passed around the abdomen at the level of the umbilicus. Then, at the point of the ensiform cartilage, also at the point of greatest enlargement, which is usually below the umbilicus, and a measurement may also be taken just above the pubes. In this way the circumference at these various points can be ascertained and recorded. It is also important to note the distance from the ensiform cartilage to the umbilicus and from the umbilicus to the pubes. If it is necessary to examine the patient from time to time, these measurements can be repeated in order to determine the variation in size.

Having completed the external examination, we are now prepared to make a vaginal examination. I take the opportunity of saying at this point that no one would be justified in undertaking abdominal incision without completing any examination which has been made by a vaginal examination. I can recall at this moment one case in which this step was neglected and the abdominal cavity was opened and a pregnant uterus found. A vaginal examination in this case would undoubtedly have revealed the existence of pregnancy, and the patient would have been saved the rather dangerous operation of abdominal incision. For the purpose of a vaginal examination the patient should lie on her back and should afterwards be changed to the side. The finger, well anointed, should be passed into the vagina and at once seek the cervix. Having examined the cervix, the finger should be swept around the neck, and as it is withdrawn palpation should be made anteriorly, laterally, and posteriorly. Then bimanual examination should be practiced, with the finger of the right hand in the vagina, pressure being made over the surface of the abdomen with the left hand. In this way information can be obtained in regard to the connection of the growth with the uterus. Other points of information which can be obtained in this way are the following: A cystic tumor occupying the pelvic cavity can be felt through the vaginal wall. A solid tumor can be felt in the same way. So with the finger introduced into the vagina, the occupation of the pelvic cavity can be determined through the vaginal walls. As I have already stated, fluctuation can be obtained with the finger

in the vagina, percussion being made on the surface of the abdomen with the other hand.

It is also necessary to introduce the sound into the uterine cavity in order to determine the condition of the uterine canal. It is desirable that beginners in performing this operation should use the speculum. After years of experience, one may be enabled readily to introduce the sound without danger into the cavity of the womb without a speculum, the finger of one hand being introduced into the vagina and placed on the cervix and the sound being carried along this as a guide. There are so many dangers, however, which present themselves in the introduction of the sound in cases of uterine tumors, that it is desirable to use the greatest care in the introduction of the sound into the canal. It should not be forced, but the way should be felt. It frequently happens that there are displacements of the uterus by reason of the pressure of the growth, whether this be solid or cystic in character. With regard to the presence of cystic growths, the information obtained by passing the sound into the uterus relates rather to the mobility of the uterus and to the fact of its being drawn up from the cavity of the pelvis or forced down into the cavity. On the one hand, we may assert with reasonable accuracy that adhesions exist if the uterus is found to be drawn up into the cavity of the pelvis and held in a fixed position; and on the other hand, we may infer that the cyst is impacted in the cavity of the pelvis, if the uterus is in a state of flexion, either antero or retro, and is immovable in its position. In fibroid growths, especially of the submucous and mural varieties the sound will give valuable information as to the seat of the fibroid tumor.

With the speculum we can ascertain the color of the mucous membrane of the vagina and the color of that covering the cervix. This is regarded as a matter of importance, as in the pregnant female the color is of a purplish hue, which is thought to be diagnostic. Another point to be ascertained with the finger in the vagina is the condition of the cervix, as to softness or hardness.

In addition to the examination by the vagina, it is sometimes desirable to make an examination by the rectum. By this means the existence of growths which cannot be readily reached in the vagina can be determined. An enema should be administered beforehand in order to unload the lower bowel.

It is also well to complete the examination by the introduction of the sound into the cavity of the bladder. With this instrument in the bladder, and the finger in the rectum, bimanual manipulation can be made which will assist in the detection of tumors occupying the pelvic cavity.

In order to illustrate the points to which I have alluded, I shall next examine the patient now upon the table. She has been prepared by the removal of all unnecessary clothing and of all constrictions

around the waist. The abdomen is exposed, and on inspection we observe that it is irregular. In the median line there is a projection, and on the right side there is another. The observance of two irregular points upon the surface gives us certain information in regard to the nature of the growth which occupies the cavity of the abdomen. It excludes certain conditions. For instance, pregnancy. In pregnancy there is a uniform enlargement of the abdomen, and the surface is not irregular as in the present instance. Inspection does not enable us to say whether these irregularities are due to pedunculated fibroid tumors or to exogenous cysts forming part of an ovarian cyst, but it does enable us to say that this is not a case of pregnancy and not a case of simple cyst.

Palpation is the next method to be employed. By making pressure with two or three of the fingers over different parts of the swelling, I can easily feel beneath the abdominal wall a hard, resisting mass which is not elastic. This would seem to indicate that the growth is solid and not cystic. Palpation elicits the same sensation over all parts of the growth. We cannot say positively from this examination that this is not a very dense multilocular cyst. You may be able, after much experience, to determine very slight shades of difference in the elasticity, which can be obtained even in cases of dense multilocular cysts. So far as I can ascertain from palpation, I am inclined to believe that we are dealing with a solid tumor and not a cyst. Not only do the fingers determine the presence of a hard, unyielding mass, but those projections which were noticed on inspection can be further outlined. Slightly to the right of the median line is a large mass which appears to be attached to the uterus by a broad pedicle. On the left is another mass, and below the tumor on the right there is a small mass which seems to be somewhat moveable. This would seem to indicate that these growths are fibroid tumors which are attached to the body of the uterus by either broad and short or narrow longer pedicles. In the former case being called sessile and in the latter pedunculated or pediculated growths.

You will observe that the brownish line reaching from the umbilicus to the pubes, which has been referred to, is present in this case.

Next, I shall practice percussion. Beginning at the ensiform cartilage, and percussing in the median line, there is, as you observe, resonance down to this point, about two and a half inches above the umbilicus. Here the sound suddenly changes into that of dulness or flatness. As I pass downward in the median line, the same flat sound is elicited below the umbilicus. As I pass on either side of the median line from the point before mentioned, the dulness is found to exist there also. The patient is next turned on the left side, and percussion performed over the right lumbar region and

lateral side of the abdominal cavity. At this point we find the dulness which belongs to the liver, and as we pass downwards we reach the resonance belonging to the ascending colon. Turning the patient now upon the right side and percussing over the left side, we find in the posterior part of the lumbar region, the resonance depending on the presence of the descending colon. As we come to the median line, the sound becomes dull or flat, showing that this mass projects more into the left side than into the right side of the abdominal cavity.

Testing for fluctuating, I find it impossible to obtain any wave. We can therefore say that there is no fluid, either in the abdominal cavity proper or in any cyst contained in the abdominal cavity.

Continuing the examination, I place my ear over the abdomen at the point which I have before mentioned. I am, however, unable to hear any sound which may be regarded as indicating the presence of a foetus in the uterus or any aneurismal bruit which would be found in dilatation of the aorta. Auscultation, therefore, gives altogether negative signs in this case.

Examination per vaginam shows that the uterus is small. The cervix is slightly elongated and that of a woman who has not been pregnant. The uterus is fixed and immovable in a position of marked retroflexion. Palpation through the vaginal walls reveals the presence of hard, unyielding masses. These, so far as can be ascertained, are attached to the body of the uterus. Owing to the displacement of the uterus, it is impossible to introduce the sound completely. It simply passes into the cervix, but not beyond the internal os.

Rectal examination has not been made, nor has any examination by the bladder been made, as the symptoms were sufficiently prominent and characteristic to enable us to arrive at a conclusion without employing this manipulation. In any case of doubt, however, it is necessary that examination by the rectum and bladder should be made as before stated.

Having passed in a systematic manner through the different steps of the examination, we are enabled to arrive at a conclusion in regard to the nature of this growth. In other words, we are prepared to make the diagnosis. From what I have seen, and from what I have felt, I am prepared to say that we have here fibroid tumors which are of the subperitoneal form. Whether the uterus itself is involved to any great extent cannot be positively determined, owing to the impossibility of introducing the sound. It is, however, quite possible that in addition to the subperitoneal form of fibroid tumors there is also the mural form or that in which the body of the uterus is affected.

Before passing to the question of treatment, I would say that there are three varieties of fibroid growths, or if you choose to call them so, of fibro-

myoma or fibro-myomatous growths. These varieties are the subperitoneal, in which the tumors lie beneath the peritoneum; the interstitial or mural, in which the tumors are located in the substance of the uterus itself, and the submucous, in which the tumors are situated beneath the mucous membrane of the uterine canal. In the subperitoneal variety the tumors project from the surface of the uterus, being covered with a layer of peritoneum and sometimes attached to the body of the organ by a broad and short pedicle, in which case, as I have said, they are called sessile growths, or by narrow and long pedicles, in which case they are called pedunculated growths. In those cases in which the pedicle is small and long, the mass can readily be moved about the cavity of the abdomen. Not only so, but it falls about if no adhesions exist, as the patient changes her position from side to side or rises from the recumbent to the erect position. In the case of mural tumors, which, as already stated, occupy the substance of the uterus, the organ is uniformly enlarged. Where they exist without the presence of subperitoneal or submucous tumors, the uterus is uniformly enlarged, as is found in pregnancy. In the submucous variety the growths form beneath the mucous membrane and project into the cavity of the uterus. Sometimes they get into the canal, and the contraction of the muscular fibres forces them on down until they escape from the cervix, forming what are known as polypi, the pedicle being in these cases elongated so as to permit the growth to pass into the cavity of the vagina. Frequently these submucous fibroid tumors are very large, and they do not pass into the canal and become pediculated, but distend the cavity of the uterus and change the direction of the canal.

The symptoms in the submucous and mural varieties of fibroid tumors are largely connected with the menstrual flow, and they relate to an increase of the flow. I have had some patients who have lost enormous amounts of blood at these periods. This is a prominent symptom and should always lead to a suspicion of this form of growth. Hemorrhage at the menstrual period is not so marked in the mural as in the submucous variety. This symptom may be entirely absent in the subperitoneal variety of fibroid tumors.

I next come to the question of treatment. At the present day, various methods of treatment are practised. In the first place with regard to medication. Mural and submucous growths are amenable to treatment by means of such remedies as ergot, which, by contracting the bloodvessels of the organ, diminish the nutrition, and in that way limit the growth of the tumor. There has been sufficient experience obtained in the use of ergot and its preparations to warrant the conclusion that these forms of growth can be positively limited. Whether or not they can be ultimately removed, is still a question, but their growth can be checked. Ergot

is not of as much value in the subperitoneal variety, especially in the pedunculated form, where the pedicle is long and narrow. It may be of some service where the pedicle is broad, as in the sessile growths, and where the effect of the remedy can reach the bloodvessels of the attached mass. The muriate of ammonium was employed by the late Dr. W. Atlee, who regarded it of value in the treatment of fibroid growths of the uterus.

After these remedies, operative interference may be employed, but there are two very important questions or conditions to be considered before any operation is to be decided upon. In the case of fibroid growths in which the menstrual flow is so great as to drain away the life of the patient, it may be justifiable to interfere with the knife. There is also another condition which would warrant operative measures, and that is the enormous size of the mass, making it a burden to the patient too great to bear.

In regard to operative interferences, the menopause can be anticipated by the removal of the ovaries. If any operation is to be performed, the removal of the ovaries, which is much less dangerous than extirpation of the uterus, is the one to be adopted. There are to my mind very grave objections to the performance of operations for the removal of fibroid masses which involve the body of the uterus or which are attached by very broad pedicles to it, and which are adherent to the viscera or abdominal wall.

A patient with a uterine fibroid can enjoy life and the growth can exist indefinitely without interfering with health. I have at this time under my care a number of patients suffering from fibroid tumors in whom I have practised the hypodermic injection of ergotine, or the aqueous extract of ergot, for a number of years. In one of these cases, I have used ergotine for the past eight years. Measurement of the abdominal enlargement in this case shows that the growth has not increased. It has, on the other hand, not markedly decreased. The patient does not lose much blood during her menstrual period, and is not rendered uncomfortable by the presence of the tumor. She is able to take part in all the enjoyments of her home, to ride out in her carriage, and to enjoy the company of her friends. I am quite sure that if I were to interfere in this case with a surgical procedure, I should terminate the life of my patient. In another case, in which I used ergot for three years, a most desirable result was obtained. In this instance, the growth was of the submucous variety. After the lapse of nearly three years, I observed that the mass was softening; and on palpation and percussion, fluctuation could be distinctly obtained. I also examined the mass from the cavity of the uterus, and found that there, too, it was softened, and fluctuation could be obtained. I therefore determined to incise the wall of the canal, which I

did, and a mass of offensive fluid escaped, containing broken down debris of muscular and fibrous tissues. My patient suffered greatly from pyæmic symptoms, and was very ill for a number of days; but by the vigorous use of antiseptic methods, washing out the cavity with antiseptic agents, as the solution of carbolic acid, surrounding her with the best hygienic conditions, and by the employment of tonics and stimulants, I was able to carry her through this critical period occupied by the evacuation of this large cavity formed by the breaking down of the tumor. Other instances of this kind have been recorded in which the effect of ergot was markedly seen. I can only explain this transformation of the solid growth to the fluid or semi-fluid condition by the cutting off of the nutrition of the growth, and the production of positive gangrene.

There are instances on record in which incision of the lining membrane of the canal has been made and ergot afterward given. In this way submucous fibroid tumors have been delivered. When the delivery has not been complete, the surgeon has interfered, and has removed the mass by cutting away portions of it at different times. This operation is attended with many dangers. Some of these dangers result from septic infection and shock. There is also the danger of the occurrence of hemorrhage.

From the examination of the case before you, the treatment which I should adopt, would be the long continued use of hypodermic injections of ergotine, and this failing, the performance of oöphorectomy. I may say, in regard to the hypodermic injection of this remedy, that the injections should be made in the abdominal wall; and in order to avoid the occurrence of abscess, it has been my practice to carry the needle of the syringe deeply into the tissues, not stopping until the muscular structures have been reached. In none of the cases in which I have used ergotine in this way have I met with abscess. As a precaution I have frequently painted tincture of iodine around the puncture made by the needle. The form of ergot used is that known as Squibb's aqueous extract, made in a solution, the strength of which is one grain to the minim. Of this solution, I have given 25, 30, and 35 minims without producing any undesirable symptoms.

THE TREATMENT OF HYPERPYREXIA BY COLD APPLICATIONS TO THE ABDOMEN.

In a recent clinic in the *Pennsylvania Hospital* reported in the *Col. and Clin. Record* Dr. Da Costa gave the following interesting cases:

The case now before you is one of typhoid fever, only remarkable for a sustained high temperature

persisting in spite of various remedies. The temperature in the morning was 103° F., and occasionally 102 , in the axilla, but for nearly a week the temperature remained at 104.8° . As there had been no marked exacerbations in the temperature, we looked upon it as a case of grave character, on account of the sustained fever. With reference to the intestinal lesions, as manifested at least by the occurrence of symptoms of bowel disorder, they were not severe: he had only three or four stools a day. The eruption was well defined, but there is nothing in the case to which I wish to call your attention besides the temperature record.

Let us see his present condition. His temperature this morning is $100\frac{1}{2}^{\circ}$; last night it was $101\frac{1}{2}^{\circ}$. I, therefore, think that the disease is yielding. The bowels have not been opened for thirty-six hours, and tend to constipation. He is very deaf, but obeys intelligently when I can make him hear. His tongue is moderately dry and slightly fissured; it is tremulously protruded. I want you to observe this cracked, dry condition, with the yellowish coating upon it; though it is not very dry, it still impresses you as a dry tongue. His abdomen is rather prominent and tender; a few spots of eruption are still visible upon the surface. There has been some atony of the bladder, so that the urine has had to be frequently drawn with the catheter. Examining his heart, I notice that there is almost complete extinction of the first sound; it can just barely be heard. The pulse beats only one hundred in the minute, even with the excitement of coming before you; but, as I see upon the record, it has never been a rapid pulse. It is compressible, but has decidedly more volume than it had a few days since. His general condition is improving with the reduction in the temperature. He has been taking dilute muriatic acid (gtt. v) and turpentine (m x) every two hours. He also takes twelve grains of quinine daily; and six ounces of wine and six of whiskey: therefore he is freely stimulated. His food consists of milk and beef tea, two pints of each in the twenty-four hours.

Now I have given you a statement of his treatment, with a single exception, and that is what I wish to develop in our discussion, viz.: the treatment of the high temperature. When I found that this man had, a week ago, an evening temperature remaining persistently at 104° , I tried to reduce it by large doses of quinine, sixteen grains daily; and on one day he took ten grains morning and evening. He was also frequently sponged with cold water. The effect was but slight; the temperature remained high. I then directed that cloths wrung out of ice water should be laid upon the abdomen until the desired result was obtained. It was found that this was more efficient, and the temperature was at once reduced to 100° , so that by this means we were enabled to keep the temperature within bounds, and thus to gain time. We discussed the

expediency of putting him in a bath, but, as he was very weak, and the bath room is some distance from his bed, rather than subject him to the risks of so much handling, we yielded the point, though, if the bath had been more convenient, I would have preferred it. I wish to call your attention especially to the use of ice water applications to reduce temperature, as a substitute for the large doses of quinine, and cold baths, which are not always convenient. It is a most instructive case. Indeed, I consider that the man's life has been saved by this means. Taking into consideration the rising temperature and the failing circulation, as shown by the impaired heart sounds, it did seem likely that the case would not get well. I would call your attention to the fact that in this case the quinine failed to reduce the temperature. It does not often fail, but it did here.

Another point is this deafness which you have observed. I almost had to shout to him before he put his tongue out. The resident physician tells me that he has been so since he came in; therefore it was not the effect of the quinine. Deafness in typhoid fever is not uncommon, and I may state that it does not contradict the use of quinine; by no means. It is due to the state of the blood and the impaired nervous system. We also note here that he has a constant tendency to stupor, is rather drowsy and heavy; he sleeps well at night without opium; he has not been delirious, and has not suffered with headache. The deafness, therefore, is the only symptom referable to the nervous system. There is very little if any, jerking of the tendons, or tremor.

Now, gentlemen, with regard to the treatment I shall make a slight modification. Quinine need only be given in tonic doses. We will order him to take eight grains daily. The dry tongue indicates that the turpentine is still useful; the amount of acid is so small that it does not make much difference whether it be continued or not, but, as it is grateful to the stomach and aids digestion, we will continue it also. Sponging of the general surface with water will be done several times a day, as heretofore; and if the temperature again rises we will return to the ice water applications. With regard to the amount of stimulant, although it seems large, yet I will not reduce it, on account of his dry tongue and weak heart. I think that just now it would be dangerous to make any change.

PILOCARPINE IN ACUTE ERYSIPELAS.

I have here a case to show you which I think will interest you, as it brings out rather a novel treatment of erysipelas. I intended to exhibit this to you this morning as a case of erysipelas, but I find that the erysipelas has gone. I, therefore, can only speak of the treatment, which has proved more quickly efficacious than I supposed it would.

This man B. K., 32 years of age, a fireman, was

admitted only yesterday. This is the record upon admission: "He says that he was quite well yesterday (November 12), but he did not go to work, as he was celebrating the election. In the evening, according to his statement, he was not drunk, though he had been drinking a little, and became engaged in a very earnest political discussion, when some one, equally earnest, struck him in the right eye, making a bruise on the cheek and a small lacerated wound on the eyebrow," the evidence of which you may see for yourselves. The man at that time was quite well, although under the influence of liquor. "During the night he had much pain in his eye, and in the morning the eyelids were oedematous and the cheek likewise swollen, red and burning." When he applied for admission the inflammation was confined to the right side of the face, but it spread rapidly, and the same afternoon both eyes were closed. It is worth adding this to his history that he had slept out all Wednesday night after receiving the injury. He was admitted on Thursday morning, with erysipelas of the upper part of the face, which was rapidly spreading over the brow. His pulse was 80; temperature, 102.8°; respiration 22. The urine was examined, with a negative result. He was ordered tincture of the chloride of iron, twenty drops every three hours, but only received one dose; as the disease was rapidly spreading, and something was needed to make a prompt impression, I used another and more active agent. This was not the first case in which I had used this remedy, but it was the first in which I obtained such rapid relief. He received, hypodermically, one-sixth of a grain of the muriate of pilocarpine. The result was remarkable. Here is the temperature record: the temperature fell from 102° to 99¼°. He sweat profusely for an hour and a half, and there was no further development of the erysipelas; not only did it not spread further, but what did exist quickly subsided. No local treatment was employed, not even cold applications; therefore, whatever success was obtained was from the pilocarpine.

I call your attention to this treatment of erysipelas. I said that it had not been my first case, although it was the most striking case I have seen. As long as five years ago I used jaborandi in the treatment of erysipelas until sweating was produced, and, I thought, with the result of checking further development. In one case, with high temperature the disease had already made some headway, and did not subside so quickly. Under the use of iron the disease had not been controlled, but the fluid extract of jaborandi, given every two hours, checked it. I have since used the jaborandi in connection with the iron at times, with good results. This is, therefore, not a new treatment with me, as I have used for some time. Jaborandi and pilocarpine, its active principle, are, of course, similar in their effects.

I have called your attention to this treatment, not because I believe that it will be followed by the same result in every case, but because it is worthy of a trial. If you get a case of erysipelas in its beginning, use pilocarpine. It has saved this man a long and dangerous illness, and, as he had been drinking, as he said he had, the results might have been serious. In the use of this treatment it should be borne in mind that, in order to be fully effective, profuse sweating must be produced.

MALARIAL SYMPTOMS FOLLOWING SURGICAL OPERATIONS.

M. Verneuil has already called attention to this subject, which is one that should be of special interest to New York surgeons, seeing that it is the fashion in this city to ascribe to "malaria" a number of obscure symptoms which can not be conveniently assigned to any other cause. Dr. Baruch has alluded to the fact that much of the "malarial disease" of New York is wrongly so called, since the most striking phenomenon of this affection, its periodicity, is frequently absent. But, while he insists upon the desirability of making a positive diagnosis to that effect only in cases of frank intermittent fever, perhaps he does not lay enough stress upon the peculiar masked forms of the disease which undoubtedly abound among us.

It is a common experience with our surgeons to meet with sudden and unaccountable elevations of temperature after operations, elevations which can not be attributed to the condition of the wound, or to the occurrence of inflammatory complications. This phenomenon is apt to cause no little uneasiness, especially in peritoneal surgery, in which a sudden rise of the index at an early period is well known to presage the invasion of peritonitis. But this occurrence is not confined to major operations, since trifling manipulations of the uterus, such as trachelorrhaphy and curetting, may be followed by fever, which is equally alarming, being suggestive of parametric inflammation. Now, a peculiarity of this rise of temperature (which is often accompanied by a rapid pulse and a good deal of constitutional disturbance) is that it observes a sort of periodicity. In the morning the thermometer will register as usual in uncomplicated surgical cases, while toward evening, on visiting his patient, the attendant will be surprised, and often alarmed, to find a reading of 103° or 104° F. The wound is examined, the patient is interrogated, but, aside from a confession of restlessness and nervousness, nothing can be elicited to explain the fever. There may or may not have been a preceding chill; generally it will not have been recognized. As the patient convalesces, these mysterious symptoms will disappear. With the administration of full doses of quinine, according to the ordinary rules observed

in using this drug for the cure of intermitent fever, the attacks will generally be cut short in two or three days. In most of the cases which have fallen under our observation, either a history of malarial exposure could be obtained, or subsequent observation of the patient after complete recovery from the operation showed that the disease was present.

The interesting point in this question is, what peculiar condition of the system is induced by a surgical operation whereby latent, or masked, malarial disease becomes actively developed? This we do not pretend to answer. It is akin to the sudden appearance of delirium tremens after injuries. The practical interest of the subject lies in the inference that the surgeon should not allow a rise of temperature *per se* to disquiet him—indeed this is only another phase of the question which Nothnagel has lately brought into prominence.—*N. Y. Med. Jour.*

EXCISION OF THE KNEE IN PREFERENCE TO AMPUTATION IN CERTAIN DEFORMITIES OF THE LEG.—Dr. Stephen Smith, of New York, read a paper with this title, at the New York State Medical Society meeting, December, 1884. There was a certain class of cases in which the question of excision at the knee, or amputation at or below that point, was to be determined. They were those cases in which the leg was rendered useless for locomotion, closely allied to those cases of deformity and displacement in which there was chronic inflammation, and the weight of the body could not be borne on the limb. The solution of the question would depend upon two points: the comparative safety of the two operations and the comparative usefulness of a stump after an amputation at the knee-joint, and at a point immediately above or below that point. Out of fourteen cases of partial excision, but two patients died, which was a mortality of only two per cent., showing a difference of eight per cent. in favor of excision. In a large collection of cases, amputation below the knee gave a mortality of thirty-four per cent., and amputation above the knee gave a mortality of sixty-three per cent. Although these figures showed that excision was by far the less dangerous, for purposes of comparison he would place them on the same footing. Perhaps the greatest weight of authority on the question had been furnished by the late Dr. Hudson, of this city, who was employed by the Government for several years. Much as he favored artificial limbs, he always regarded an ankylosed knee as more serviceable than a stump to which an artificial limb might be adjusted. In the light of these facts, we might formulate conclusions in regard to these operations as follows: That excision at the knee-joint was quite as safe as amputation above or below that joint; that excision of the knee-joint was to be preferred to amputation, by which the leg was rendered useless.

Dr. S. W. Gross, of Philadelphia, took it that excision of the knee-joint was not the proper operation in all cases of deformity of the knee; for instance, in cases of ossification or synostosis of the joint he saw no necessity of resorting to excision at all. In such cases it had been his practice, and that of his father, the late Professor Samuel D. Gross, to make an incision across the knee, and break up the osseous union with a chisel. Then the patella could be separated from its adhesion to the femur by force applied to it through a towel interposed. Then, on account of the danger of rupturing the popliteal artery, it was not safe to attempt to straighten the limb entirely at once, but it was best to bring the foot down only so far as was necessary to make the toes touch the floor—the heel, he thought, should swing about an inch above the floor. Even this it was safer to accomplish gradually, at several operations, the patient being anesthetized each time. This operation, he thought, should be more widely practiced in preference to excision, as had been taught by the late Professor Gross, in his "Surgery." In regard to the statistics brought forward by the reader of the paper, he would say that they had been materially changed within the last five or six years, and no surgeon who resorted to antiseptic precautions would expect to have a mortality of more than three or four per cent. after amputation of the leg.—*Medical Record.*

TREPHINING IN MASTOID AND TYMPANIC DISEASE.—Dr. W. J. Wheeler, of Dublin, at the conclusion of an article on this subject, says:

Of the 35 cases in which the trephine was used, 4 terminated fatally, while the result in the other cases has not been reported; in the total number of cases, the results of which are differently specified, 17 per cent. were fatal, and 21 per cent. successful. Buck has collected 37 cases of suppurative inflammation in which the cases were left to nature (expectant treatment); 34 were fatal. It will be readily seen from the foregoing that the operation of trephining for mastoid disease is a fairly successful one, and, on the other hand, that, from the expectant treatment in suppurative inflammation there is little to look forward to but a fatal result. That the operation should be practiced early is a self-evident fact; it is useless when pyæmia, meningitis, or phlebitis of the sinuses has appeared, although the first cerebral manifestations should not intimidate the surgeon from operating, and I doubt not but that good service will be done toward the patient by his attendant who advises operation even where no bone disease existed, but when the discharge from the tympanum has lasted for a *lengthened period*, and has not yielded to other treatment, such as syringing and enlarging the opening of the membrana tympani if necessary. Setons and issues I believe to be of little use, for

although only the mucous membrane may be engaged, yet we know that a blow on the mastoid process, a severe cold, a depressing illness, may cause disease to advance to the bone, pyæmia may ensue, or death by general cerebral irritation, without the formation of abscess. A well-accomplished operation will always give free vent to pus when existing, and prevent it passing to the brain through some of the numerous channels I have recorded, and will thus save the patient. I must deprecate the operation recommended by Dr. Bagroff—namely, the use of the gouge and galvano-cautery over the mastoid process; such procedure, as it appears to me, would be likely to set up irritation and inflammation. Unless, indeed, the suppuration is comparatively superficial, or discharging through a fistulous opening, I would not select to operate over the mastoid process; there one cannot remove the entire portion of the bone, on account of the proximity of the lateral sinus, and so cannot expose the dura mater, to do which I hold is very essential.

The site I would always select for operation, with the exceptions as above named, would be such as to place the lower border of the trephine on a level with the external auditory meatus, and anterior to a line dividing vertically the mastoid process. By adopting this course there will be no danger of wounding the lateral sinus, the tympanum and mastoid cells will be opened, giving full exit for discharge, the dura mater will be exposed, and should pus exist between it and the cranium, there will be ample freedom for its escape.—*Dublin Journal of Med. Sc.*, October, 1884.

DISINFECTANTS.—At the close of a paper on this subject, Dr. W. J. Miller, of Dundee, draws the following conclusions:

"1. It is very doubtful that any efficient disinfection of a room can be practised while it is occupied. Nevertheless, it is possible that the presence of a disinfectant, though not in sufficient concentration to kill contagium, may, by long continuance of operation, weaken it, and, if microzymes be the contagium, may so lower their vitality as to impair their power to reproduce their kind. A certain degree of probability is given to this by Prof. Tyndal's observation of the effect of continuous heating in sterilizing putrescent liquids, which led him to conclude that there is a period in the life-history of these minute organisms when they are especially vulnerable. It is therefore, in the direction of good to employ some disinfectant during the progress of the case, and there is none equal, either in efficiency or in simplicity of application, to sulphur. It is exceedingly convenient in practice to use sulphur pastiles, as introduced by Dr. Littlejohn, each of which contains twenty-five grains of sulphur, one or two being used at a time, according to the size of the room. This should be done several times a day.

"2. The skin of the patient should be sponged several times a day with diluted acetic acid, by preference with the aromatic. This is especially applicable in scarlet fever, effectively disinfecting the desquamating skin. I only mention the method of inunction to condemn it emphatically. The strength of the solution must be regulated by what is found agreeable to the patient; a 1 to 20 solution of the aromatic acid, which has been referred to, is generally too strong.

"3. For the final disinfection of the sick room nothing equals sulphur. But it must be thoroughly applied. The Dundee sanitary authority uses about three pounds of sulphur to a room about ten feet square, carefully closing all apertures by which the fumes can escape, and leaving the room shut up for about four hours.

"4. For disinfection of clothing, etc., the method followed here is exposure to a temperature of about 250° for three hours in a specially constructed chamber, the air being also charged with the fumes of about six pounds of sulphur. It is scarcely possible that any contagium can live through such an ordeal.

"5. Excreta of patients are best dealt with by Dr. Dougal's method—namely, mixture with hydrochloric acid diluted to 1 to 20. He has proved that this solution does not injure the metal fittings with which it comes for so short a time in contact. Clothes may also be thoroughly disinfected by this agent, and without injury.

"6. For hand disinfection, carbolic solutions 1 in 20, acetic acid, and sulphurous acid, are almost certainly thoroughly effective.

"7. The question of disinfectant inhalations for lung disease, especially phthisis, demands a longer consideration than can here be given to it, but, when we consider that vaccine which has been exposed for three hours to air saturated with creosote vapor, and similarly for four hours to the vapor of eucalyptus, retained its infectivity unimpaired, that the germs to be acted on are far in the recesses of the air-vesicles, and that the inhaled disinfectant can only reach them in very weak dilution, if indeed it reaches them at all, it appears to me, although it is very disappointing to arrive at such a conclusion, difficult to place much confidence in this therapeutical expedient."—*Practitioner*, Oct '84.

THE PAINLESS EXTINCTION OF LIFE.—The *Med. Press and Circular* states that: Dr. Richardson's lecture on "The Painless Extinction of Life in the Lower Animals," at the Society of Arts last week attracted a very large audience, among whom we noticed many members of the profession. The lecturer prefaced his subject by stating that he had, at the request of the Committee of the Dog's Home, Battersea, constructed a lethal chamber for the painless extinction of the life of dogs which nobody owns, which must of necessity be destroyed.

He put the process into operation in May last by subjecting thirty-eight dogs to the fatal vapor, and all passed rapidly into sleep and from sleep into death. Since then from 200 to 250 dogs per week have been painlessly killed in the chamber. The number struck us as unusually large, and we were almost tempted to ask what the anti-vivisectionists were about, and why they so cruelly abandoned so many of their pets—7,000 in a few months—to starvation or to the tender mercies of the police and the uncertainty of prussic acid. The numbers, however, Dr. Richardson said, had been exceptionally large and the experimental results so entirely practical and successful that he felt the time had come for him to place them fully before the public. The process at first was not unaccompanied with difficulties—first, in determining the anæsthetic to be employed, and next as to the most efficient form of chamber in which the animals should be exposed to the lethal gas or vapor. Out of a list of twenty-two anæsthetics he had selected four of the best known among them, which he subjected to a careful series of trials, and of these he finally selected carbonic oxide as the easiest to deal with and the least expensive. The lethal chamber is filled with gas by an ingeniously constructed Clarke's stove.

As to the painlessness of the death of the dogs, there can be no doubt whatever, and Dr. Richardson firmly believes that the same method might be used for the destruction of those animals which supply us with food. Indeed, he has already tried it with sheep, which are put down to sleep with the greatest rapidity before being slaughtered, and it has been found that the carbonic oxide exercised no prejudicial influence over the flesh of the animals, nor did it unfit it in any way for the market as food.

The same process is found equally applicable to swine, calves and fowls, so that steps have been taken to carry out the lethal process on a large scale. The objection even to retention of blood so strongly felt by the Jewish people do not obtain by the process, as the animals in the sleep of death are found to yield up blood just as freely as in the ordinary way, or when no anæsthetic is used.

Upon the issue of these experiments Dr. Richardson deserves the gratitude of the entire community. Looked at from whatever point, his efforts were praiseworthy, and the results constitute a triumph to science and a boon to the lower creation. If—as he eloquently concluded his lecture—Science sometimes, for the sake of man, inflicts pain on the lower creation, here she relents, and does for the lower creation what she dare not do for man.

CREDE'S METHOD OF DELIVERY OF THE PLACENTA.—Dr. W. H. Taylor, in the *Cincinnati Lancet and Clinic*, says: The vigorous controversy over "Crede's method," which has recently involved so many obstetricians, has led Crede to re-

state in detail the manipulation he advises. As many American practitioners habitually adopt what they believe is his practice, I think it will be of interest to know exactly what that method is, I therefore have translated his own description, giving the italics as found in the original, in the *Archiv. für Gynakologie*, xxiii, 2, 213:

... "The natural detachment of the placenta occurs within a few minutes after the birth of the child, and is recognized by a discharge of blood and by marked diminution of the size of the uterus, which may now be felt as a firm ball, the size of a child's head, between the umbilicus and pubes. As soon as any after-pains have occurred the midwife grasps the entire uterus through the abdominal walls with both hands and presses it toward the concavity of the sacrum, she repeats this *several times*, if necessary, *but only during a pain*, until the placenta is found at the vulva or is entirely expelled. If, from imperfect contraction of the uterus, or from tenderness of the abdominal walls, sufficient pressure to expel the placenta can not be made, the attendant, guided by the umbilical cord, feels carefully in the vagina for the placenta; if a portion is felt, then, with one hand, *gentle traction* is made on the umbilical cord, while with the other pressure is made over the uterus. If the point of insertion of the cord in the placenta can not be reached, or if on *gentle traction* of the cord resistance is felt, no further effort to deliver the placenta in this way may be made until after *several uterine contractions* have occurred, which may be increased by *gentle rubbing* and pressure. If the placenta is found low in the vagina, and readily reached by the finger, then the attendant shall pass the index and middle fingers as far upon the placenta as possible and press it gently downward and backward, while with the left hand the cord is made tense. When the placenta appears at the vulva the attendant shall grasp it with the fingers of one hand, and draw it gently upward and slowly turn it upon itself several times in order that the membranes may form a cord and not be torn away. When delivered the entire after-birth and any coagula are removed under the flexed leg of the woman and placed in an empty basin.

"*All strong traction* on the umbilical cord, or attempts to extract the placenta when high up by introducing a part or the whole hand, or to aid the efforts at extraction by straining, coughing, blowing in the hands, etc., are *very dangerous* and therefore are *forbidden*."

HIP-JOINT AMPUTATION. — DAVY'S LEVER.—The following important cases under the care of Mr. Haward, of St. George's Hospital, London, are reported in the *Lancet* for January 3, 1885:

John D—, aged twenty-four, received in May last a blow on the right buttock from the buffer of

a locomotive. When admitted soon afterwards into St. George's Hospital, the buttock presented near its most prominent part a contused and lacerated wound large enough to admit a finger. Out of the wound dark blood oozed very freely. The soft parts were very extensively undermined, and beneath them was a large and increasing collection of blood. This blood collection did not pulsate and no bruit was audible. A pad was firmly bandaged over the buttock for three hours. In this interval the collection of blood had greatly increased, and when the pad was removed large quantities escaped. Ether was then administered and the right iliac artery compressed with Davy's lever. When once introduced far enough, this instrument acted perfectly. Mr. Haward enlarged the wound to a length of some six inches. The gluteal muscles were found to be torn across, and beneath them existed a large cavity full of blood. This was quickly turned out, bringing into view the sciatic notch and the open mouth of the gluteal artery. This and a great many other muscular vessels were secured with catgut ligatures. No blood was lost during the operation and the man's recovery was uninterrupted.

The case shows well the value of the lever, and in connection with this subject of compression of the large vessels of the abdomen it seems well to mention a case of amputation at the hip-joint for sarcomatous disease, which also occurred in Mr. Haward's practice. Here the abdominal aorta was very effectually controlled by a contrivance more or less like that suggested by Sir Joseph Lister. The blunted apex of a pyramidal piece of wood was fixed over the abdominal aorta by an elastic bandage. The apex of the pyramid was about one inch square and covered with felt. The base measured about three inches square and presented instead of a plane surface a broad and shallow groove. The elastic bandage passed round the pelvis and along this groove. When fixed it was placed in the charge of an assistant, who, grasping the wood with both hands, could very easily and nicely direct and regulate the pressure. This contrivance caused no dyspnoea and completely checked all bleeding.

THE ENGLISH CHOLERA COMMISSION.—Drs. Klein and Gibbes have sent the following report to the Surgeon-General and Sanitary Commissioner of the Government of India. Dated Calcutta, Nov. 27th, 1884.—(*Lancet*, *Fan.* 3.)

We have the honor to report that the investigations which we have hitherto carried on in Bombay and Calcutta have yielded the following results:

1. The statement of Koch that "comma bacilli" are present only in the intestines of persons suffering from or dead of cholera is not in accordance with the facts, since "comma bacilli" occur also in other diseases of the intestines—e. g., epidemic

diarrhoea, dysentery, and intestinal catarrh associated with phthisis.

2. The "comma bacilli" in acute typical cases of cholera are by no means present in such numbers and with such frequency as to justify Koch's statement that "the ileum contains almost a pure cultivation of comma bacilli."

3. The "comma bacilli" are not present in the tissue of the intestines or elsewhere.

4. The "comma bacilli" in artificial cultivations, carried out by one of us (E. K.), do not behave in any way differently from other putrefactive organisms.

5. Mucous flakes of the ileum, taken out soon after death from typical acute cholera, contain numerous mucous corpuscles, many of them filled with peculiar minute straight bacilli. The same bacilli occur also outside the mucous corpuscles. They are never missed even when the "comma bacilli" are.

6. These small bacilli have been cultivated by one of us (E. K.), and they do not behave differently from putrefactive organisms. They are not present in the tissues of the intestine or any other tissue.

7. No bacteria of any kind, and no organisms of known form and character, occur in the blood or any other tissue.

8. A good many experiments have been carried out by one of us (E. K.), with the following results. (a) Mice, rats, cats, and monkeys were fed with rice-water stools, with vomit, with mucous flakes of the ileum, fresh and after having been kept for twenty-four to forty-eight hours. The animals remained normal. (b) Inoculations with recent and old cultivations of "comma bacilli" and the small straight bacilli, as well as with mucous flakes, were made into the subcutaneous tissue, into the peritoneal cavity, into the jugular vein, and into the cavity of the small and large intestine of rabbits, cats, and monkeys; but the animal remained perfectly well and normal.

9. The material which we have had hitherto at our disposal has been very good and abundant, and, as far as the microscopic work goes, we do not think we shall require any more material. We therefore propose concluding our inquiry by the beginning of December, and hope soon after to return to England.

PATHOLOGY OF CYSTITIS.—According to M. Hache (*Revue de Chir.*, No. 4, 1884) lesions of the bladder and irritation applied directly to its wall and mucous membrane do not constitute a necessary and sufficient cause of cystitis, except in case of vesical tuberculosis, or of the presence of a rough and irregular shaped foreign body. The causes capable by themselves of constantly determining inflammation of the bladder are very rare. Beyond tubercular cystitis, and other forms of cystitis due to some general morbid condition—as,

for instance, those of rheumatic, gouty, and infective nature, which are not of frequent occurrence—there cannot be included in the above category scarcely any save severe accidental or surgical traumatism of the bladder, and too sudden and complete evacuation of this organ after over-distension. Gonorrhœal urethritis does not often give rise to cystitis, except under the influence of some occasional cause or in a predisposed subject. Most of the predisposing causes act quite simply by determining a more or less persistent congestion of the bladder; others have a more or less obscure mode of action, although their influence is very decided. Chief amongst these predisposing causes are the tubercular, rheumatic, and gouty diatheses. These predisposing causes may sometimes become exciting causes by increase, extension, or repetition of their action, or through association with that of other causes of the same group. These latter causes are congestion and slight inflammation of neighboring organs, especially in the female; tumors, calculi, and foreign bodies in the bladder; incomplete retention of urine, with or without distension; habitual resistance to the needs of micturating, and all the causes of dysuria and functional over-activity of the bladder; stricture and foreign bodies in the urethra, hypertrophy of the prostate, etc. Finally, the part of exciting cause is more especially played by sudden and complete retention, by cold, by catheterism or exploration of the bladder. The latter cause can act only on a bladder predisposed by the presence of a tumor or calculus; the other two causes are more active, and may even by themselves suffice to excite an attack of cystitis. M. Hatché's study of the pathology of cystitis has led him to insist on the importance of congestion and diathetic influences, especially the tubercular diathesis, and on the relatively limited part played by lesions of the urethra and prostate.—*London Med. Record*.

TREATMENT OF ABSCESS OF THE LIVER.—A few years ago M. Jules Rochard reported to the Académie de Médecine a method of healing abscesses of the liver by large and direct opening, combined with the Listerian antiseptic method. This operation consists, when the abscess is only suspected, without being diagnosticated, in using the needle of an aspirator. Then if pus be found, the needle is used as a director along which a bistoury is carried, and the abscess is opened. The cavity is then injected with antiseptic solutions, and drained. About the same time, Surgeon-Major Oberlin, of the French Army, had occasion to treat several cases of abscess of the liver. He gives the history of three cases. The first case was aspirated with Potain's aspirator, a large amount of chocolate-colored pus drawn off, and the patient recovered.

The second case was that of a woman, thirty-six

years of age, about f3xviiij of chocolate-colored pus were drawn off with Potain's aspirator. The patient then had an attack of intermittent fever, and the abscess partially refilled. A little more than f3vj of pus were removed. About six weeks afterwards a third aspiration removed about f3viiij of pus. The fever continued, however, the patient got no better, and the abscess refilled. One week after the third aspiration the abscess was opened with a large trocar, the pus removed, and a caoutchouc tube introduced. A 1 to 40 solution of carbolic acid was then thrown into the cavity, and a Lister dressing applied after the injection had ceased to return clouded. The dressings were repeated daily for five days, when the first tube was replaced by a short one. The wound was completely cicatrized in a month.

M. Oberlin believes that in using the aspirator it is well to make several punctures at intervals. He also states, what is not new, but worthy of further attention, that abscesses of the convexity of the liver cause pain in the right shoulder; but this is absent in cases of abscess of the left lobe or base.—*Archive. de Méd. et Pharm. Mil.*, Oct. 1, 1884.

VOLUMINOUS ENEMATA OF NITRATE OF SILVER IN CHRONIC DYSENTERY.—Dr. Stephen Mackenzie read a paper on this subject before the Clinical Society of London (*Med. Times*). The mode of procedure he adopted was as follows: The quantity of nitrate of silver to be used was dissolved in three pints of tepid water in a Leiter's irrigating funnel, which was connected by India-rubber tubing with an œsophageal tube with lateral openings. The patient was brought to the edge of the bed and made to lie on his left side, with his hips well raised by a hard pillow. The terminal tube, well oiled, was passed about eight or ten inches into the rectum, and the fluid allowed to force its way into the bowel by gravitation. The injection rarely caused much pain, and often none. It usually promptly returned, but when long retained it was advisable to inject chloride of sodium, to prevent absorption of the silver salt. Various strengths had been used, from thirty to ninety grains to three pints of water, but usually one drachm of nitrate of silver was employed. The treatment was based on the view that, whatever the nature of dysentery, whether constitutional or local, in the first instance, the later effects were due to inflammation or ulceration of the colon, which was most effectually treated, as similar conditions elsewhere, by topical measures. Sometimes one, sometimes two injections were required, and in some cases numerous injections were necessary; but in all cases thus treated, many of which had been unsuccessfully treated in other ways previously, the disease had been cured. The cases narrated were: 1. In which the disease had lasted several years on and off; two injections were used and the case was cured in six weeks.

2. Second attack, duration uncertain; four injections used; cured in five weeks. 3. Duration two months; two injections used; cured in three and a half weeks. 4. Duration five years; one injection used; cured in three weeks. 5. Duration eighteen months; two injections used; cured of dysenteric symptoms, but remaining under treatment for diabetes. 6. Duration fourteen months; one injection used; cured in seven weeks.

Dr. Carrington said that this treatment had been tried in the hospital at Greenwich without any remarkable effect, but the injections had not been so voluminous as those used by Dr. Mackenzie, which might, perhaps, explain the fact. The colon was usually capable of holding six pints of fluid, and the three pints used in some of the cases might possibly have failed to reach the affected parts.

REMOVAL OF GALL STONES.—The *Dublin Medical Press and Circular* of October 1, 1884, says:—The current number of the *Independence Belge* mentions a surgical operation which has just been performed in Brussels by Dr. Langenbusch of Berlin, who must not, however be confounded with his eminent fellow-citizen Langenbeck. The subject of this daring and successful proceeding was M. Eugene Anspach, the Deputy Governor of the National Bank of Belgium, who has been for many years suffering from a collection of gall stones, which have kept him in a state of aggravated suffering (*doleur atroche*) and have latterly defied all measures of relief. M. Langenbusch, summoned specially from Berlin, proposed to lay open the gall bladder, with antiseptic precautions, admitting, however, that he had only performed this operation four times, and that but one of these cases had recovered. M. Anspach's family and friends were much dismayed at this announcement, and begged that the operation should not be performed. M. Anspach was firm, and reflecting that without it he would not live long, and that in the meantime his life would be worse than death, decided on the operation. Even in this supreme moment the banking mind asserted itself, and M. Anspach remarked "after all, one in four is 25 per cent., and that is a fine dividend." "You have had one recovery already, doctor," he remarked, "and I will be the second," an element of confidence which no doubt had something to say in the result. The operation was performed on the 9th September, and 125 calculi were extracted from the gall bladder. M. Anspach suffered a good deal after the proceedings, but is now out of danger and in complete comfort. We trust he will long live to enjoy the reward of his own pluck and the skill of his surgeon. It is a curious circumstance that this operation has to a certain extent been anticipated here. The late Sir Timothy O'Brien suffered from gall stones, and the late Sir Dominic Corrigan worked down into the gall bladder by means of a

potash issue, and removed them. Sir T. O'Brien's recovery was complete.

TREATMENT OF CHRONIC HYDROCEPHALUS BY TAPPING.—Dr. J. G. Palmer M.D., of Oakbowery, Ala. reports in the *N. Y. Med. Record* a case of successful treatment of congenital hydrocephalus. The patient was a negro baby, seven months old. He was called to see the child in July last. He diagnosed the case as one of congenital hydrocephalus, and told the parents that the only hope for cure was in tapping. To this they would not consent. The accumulation continued until the head reached the enormous size of twenty-six inches in circumference—the bones of the head having become very thin by reason of the pressure within. There was a space of two inches between the bones. The eyes were turned up under the upper lids from pressure upon the brain. In consultation with Drs. Garison and Spratling the importance of tapping was urged and the parents consented. A small hydrocele trocar was inserted at the posterior portion of the anterior fontanelle, the head having first been shaved at the place of insertion of the trocar. The fluid flowed freely. About eight ounces were drawn off, the trocar withdrawn, and a piece of absorbent cotton placed over the place of puncture, and held in place by a piece of adhesive plaster. The bones of the head were pressed into position, and held in place by a tightly fitting bandage. Next day bandage, plaster and cotton were removed, and more fluid was allowed to drain off, though much had done so during the night by the plaster coming off and the cotton being moved out of position. The fluid was allowed to drain off at intervals until all was removed. The child was then put upon iodide of potash, which was kept up for several weeks. The eyes soon regained their normal position. The child nursed well and fattened rapidly. There were some febrile symptoms for several days after the operation, but they soon subsided. The head is yet big from the large size of the bones, as they were very thin. The bones seem to be rapidly uniting, and the child is still fattening and growing.

INCONTINENCE OF URINE IN CHILDREN.—In his recent work on diseases of children, Dr. Eustace Smith gives the following:

Of medicines which diminish irritability, belladonna takes the first place; but it is important to be aware that this remedy, to be effectual, must be given in full doses. Children have a very remarkable tolerance for belladonna, and will often take it in surprising quantities before any of the physiological effects of the drug can be produced. In obstinate cases of enuresis the medicine should be pushed so as to produce dilatation of the pupils with slight dryness of the throat. In children of four or five years of age, it is best to begin

with twenty-five or thirty drops of the tincture of belladonna, given three times in the day, and to increase the dose by five drops every second or third day, of course watching the effect. Ergot is another remedy which is often very successful. For a child of the same age twenty drops of the fluid extract may be given several times in the day.

Bromide of potassium, benzoic acid (dose, five to ten grains) and benzoate of ammonia, digitalis, borax, cantharides, camphor, and chloral have all been recommended as specifics in this complaint. Sometimes a combination of several drugs seems to be more effectual than one given alone. I have lately cured a little girl, aged four years, who had resisted all other treatment, with the following draught given three times in the day :

R. Tinct. Belladon. ʒ j,
Potass. brom. grs. x,
Infus. digitalis ʒ ij,
Aquam ad ʒ ss. M.

Ft. haustus.

When the incontinence continues in the day as well as at night, strychnia should be combined with the sedative so as to give tone to the feeble sphincter. In these cases, too, cauterization of the neck of the bladder, with a strong solution of the nitrate of silver (ʒ j. ʒ j. to the ounce of water), has been found successful.

APPARATUS FOR CHRONIC JOINT DISEASE.—

BARWELL—Mr. B. in a clinical lecture now gives the preference over Taylor's, Sayre's, and Thomas', to the following apparatus for chronic joint diseases, the apparatus being modified for different joints. The method is one to which his attention was called by Dr. Von Wahl, Dorpat, but invented by Dr. Dumbrowski of that University. The knee-joint is taken as an example. To the knee above and below the joint poroplastic felt or leather is moulded by the hand or by bandage; while these are hardening the sound limb is placed with its posterior aspect on a piece of paper and a tracing is made of its inner and outer aspects. The circumference of the top of the thigh is taken in an oblique direction, *i. e.*, from the perineum to a point a little above the great trochanter. The splint-like moulds being removed, the instrument-maker bends two flat bars of steel or of iron, about three-fourths of an inch broad, to the shape of the tracings, only with a larger divergence at the knee and two to two and a half inches longer than the limb. These bars are to be rivited to the poroplastic felt or leather, which is provided with straps. The upper ends of the bars are made fast to a well padded ischio-iliac ring, provided in front with a hinge and flap. The lower ends are fastened by a pivot joint to a plate that underlies the sole. To put the appliance on, the leather or felt is to be

softened, the ischio-iliac ring opened; the limb being put in, the straps are buckled and the patient left at rest until the leather or felt has hardened. A high-heeled shoe is made for the sound foot and the patient allowed to go about; at first on crutches, afterwards without them. Motion can not take place at the joint, nor can the weight of the body fall upon it. The joint is at perfect rest and can be examined.—*Lancet*.

THE TREATMENT OF GASTRODYNIA.—The following instructive case is reported by Dr. John W. Martin, in the *Medical Press*.

Miss R., æt. 30, came under my care, October 3, 1884, suffering from pain in the stomach after meals, and the consequent dread of and loss of desire for food. When seen she looked quite worn and thin; complexion sallow; lips and gums anæmic; tongue whitish and lightly furred; bowels constipated. She felt a daily-increasing sense of weakness and inability to attend to her duties. Physical examination yielded negative results as regards the condition of the various organs. The case seemed one of dyspepsia consequent upon anæmia. The uterine functions were, with the exception of paleness of the menstrual discharge, normal.

I at first ordered bismuth, soda, and tr. nux vom. mixture with chloroform water; and calomel, colocynth, hyoscyamus pills to regulate the bowels. This giving no relief, I changed to pills of reduced iron and extract of nux vomica with meals, and as a laxative a mixture of sulph. mag. and mag carb., with peppermint water. Again no relief being experienced, I placed her upon the following prescription :

R. Sodæ bicarb., ʒ iss.
Tr. nucis vom., ʒ xl.
Liq. morph., ʒ j.
Sp. am. aromat., ʒ iss.
Syrupi zingib., ʒ j.
Aquæ menth. pip. ad., ʒ viij.
M. ʒ j. to be taken four times a day.

The relief was immediate, and so far has proved permanent. Pain is now rarely felt, and only after indiscretions as to food. Relish for her meals has returned. She is now taking the reduced iron and extract of nux vomica pills with meals, and finds decided benefit from them. The bowels are regular, the tongue clean, and her complexion and general appearance much improved.

I am inclined to think the small dose of opiate was just the one thing wanting in my previous treatment, to help the lame dog over the stile.

THE TREATMENT OF RINGWORM.—Dr. Smith, F.R.C.S., London, *Brit. Med. Journal*, says :—I have been trying for some time to find out what vehicle penetrates most deeply into the hair-follicles, and think it is chloroform. Chrysophanic

acid is a very good parasiticide; and, though it is insoluble in spirit and ether, yet it is soluble in chloroform. Chloroform also dissolves the fatty matter out of the hair-follicles, and thus allows the parasiticide dissolved in it to penetrate deeply. During the last year I have used a solution of seven grains of the acid to the ounce of chloroform to all cases of recent ringworm, and believe it is the most efficient treatment I have yet tried.

The small patches should be carefully marked out by cutting the hair very closely on them, and the chloroform solution should be well pressed and dabbed into the places with a minute sponge mop for five minutes, two or three times a day, according to the amount of irritation produced. The aim of the treatment is not to produce scabs, but to get the solution to penetrate deeply. The sponge-mop should not be much larger than a big pea, and should be continually dipped into the chloroform-bottle, as the solution soon evaporates while it is pressed into the diseased spot, and leaves the yellow acid dry on the place. Great care must be taken that the solution does not run on to the forehead or into the eyes, and that the person using it does not inhale the vapor. I always give full directions about the care necessary in using such a potent remedy, and only apply it to small places of the disease. It is well for the nurse to keep her face away from the sponge, and to use the chloroform in a current of air, and not in a small room. The places should be well washed every morning with hot water and soap, to remove any sebaceous matter or crusts, and the hair should be kept closely cut on them till new hair appears, which is generally in about two or three months; but the remedy should be continued till all diseased stumps have come out.

STRICT ANTISEPTIC SURGERY.—An interesting account as to how our German colleagues follow out the antiseptic treatment in operations and the dressing of wounds is found in the *Medical Press and Circular*. Before every operation the steam spray of corrosive sublimate is worked for some time to disinfect the atmosphere of the room. The floor of the operating-room is flooded with water, so that the assistants are compelled to wear rubber boots. During the operation a continuous stream of a solution of sublimate, 1-1000, is directed on the wound. In the dressing of the wound after the edges have been united, a layer of glass wool saturated with a ten-per-cent solution of sublimate is placed over it, over this small pillows of peat dipped in sublimate solution are placed, and over all this sublimated gauze. The dressings are never removed until the wound heals or some discharge shows through the dressings. The results gained by Schede, of Hamburg, in this manner are astonishing. Out of an immense number of operations performed in 1883, among which were nine

cases of resection of the hip-joint, there were only two or three cases that showed any sign whatever of suppuration.—*Louisville Med. News*.

CHARCOT'S JOINT DISEASE.—A very important discussion of this subject has recently occurred at the London Clinical Society. The names of the prominent men who participated in the debate are a sufficient assurance that the question was illuminated with the light of the best minds of the profession. The general tendency of the meeting was to consider the affection not as a distinct disease, but rather as a form of chronic rheumatic arthritis occurring in patients with locomotor ataxia. There was a disposition on the part of the surgeons present to regard the nervous theory of its production as rather an imaginative way of explaining a gross surgical condition. Professor Charcot was invited to be present at the discussion but was unable to attend.—*N. Y. Med. Journal*.

NITRO-GLYCERINE IN MITRAL LESIONS.—At the clinic, (*Col. and Clin. Record*) Prof. Bartholow gave nitro-glycerine to a patient with a mitral lesion causing pulmonic and renal congestion, albumenuria and general oedema. He thinks it the best thing we have for congestion of the kidneys, and valuable to take work off the heart, by lowering the tension. It does not interfere with nutrition, like digitalis. One drop of a one per cent. solution, slowly increased to flushing of the face, is the dose.

OBSTINATE CONSTIPATION.—The *Col. and Clin. Record* states that a woman presented herself at the clinic complaining of constipation consequent upon atony of the lower bowel. Often she had been six weeks without a passage, and at no time during the last year had she an evacuation under two weeks. Prof. DaCosta placed her upon the following treatment:

R	Magnes. sulph.,	ʒi
	Acid. sulph. dil.,	fʒij
	Ferri sulph.,	ʒj
	Aquæ,	Oij. M.

SIG.—A wineglassful ter die.

She was also given strychninæ sulph., gr. $\frac{1}{60}$, at meal times.

PASTE FOR COMEDONES.—Dr. A. Van Harlingen recommended at the last meeting of the American Dermatological Association the following formula for a paste for the removal of comedones (acne); it was first suggested by Unna: Glycerine, 3 parts; vinegar, 2 parts; kaolin, 4 parts.

The partnership heretofore existing under the firm name of Henry C. Lea's Son and Co., Publishers, has dissolved by limitation, and the business will be continued by Charles M. Lea, Christian C. Fenger, Arthur H. Lea and H. M. Barnes, under the name of Lea Brothers & Co.

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STRRET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, FEBRUARY, 1885.

The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

THE TREATMENT OF WOUNDS.

When we consider how slight a wound may cause death, the importance of the subject which heads this article becomes at once apparent. If to this be added the great frequency of wounds, we have another cogent reason for regarding the subject as one of the first importance to every surgeon. Even in this Dominion it may safely be asserted that not a minute passes but some surgeon is at work on a wound, either accidental or surgical. It cannot therefore be wondered at that much has been said and written on the treatment of wounds, or that the subject has engaged the earnest attention of the best minds in the profession all along the line of surgical progress. Since the advent of the use of antiseptics, union by first intention has to such an extent become the rule, that any surgeon valuing his reputation is expected to offer some apology in case of failure. This certainly is a wonderful advance, and implies more, in the saving of time, pain and life, than we can have any conception of. Yet there is too much reason for the belief that, outside the great centres of population, the methods by which these humane ends are reached are comparatively neglected, and that still the old method of ligature, adhesive straps, and water dressing is in vogue. True, carbolic acid is used, and more attention is paid to cleanliness; still, in the main, modern improvements do not prevail to the extent that many imagine. The chief cause of this is not far to

seek. The antiseptic treatment of wounds, as practised by Lister and his followers, is too elaborate and complicated to commend itself to those who are but seldom called upon to treat any but trivial wounds, which, as a rule, do very well under a more simple treatment. This fact without doubt has been a source of discouragement, and has engendered a spirit of apathy, not to say antipathy, towards antiseptic treatment, as well as other improvements. Now, however, that Listerism in its entirety has been shown to be very little, if any, superior to a modification of it, so simple and inexpensive as to be within the reach and capacity of all, there can be no longer any excuse for holding to practices long since condemned by those best qualified to speak.

Comparatively few surgeons operate under the carbolic spray. Most of them deem it sufficient to observe the most scrupulous cleanliness, combined with careful disinfection of hands, instruments, etc., with carbolic acid or corrosive sublimate in solution. All wounds should be thoroughly sponged with a disinfectant before being closed. Mr. Bryant, the celebrated operator at Guys' Hospital, recommends sponging the raw surfaces with hot water, impregnated with sufficient tinc. iodine to give it the color of sherry. This is the antiseptic used by Mr. Garrard of Sheffield, and other well-known surgeons. This method is considered by many superior to the spray, since the heat has the power of sealing up the minute vessels by coagulation. This solution is also a valuable styptic in all operations where there is oozing from a great number of small vessels. The introduction of the cat-gut ligature, which is cut short and eventually absorbed, is a great advance in surgery, and should be employed wherever it can be relied upon. This is Lister's method of securing arteries. Bryant, on the other hand, uses torsion only, even in the case of large arteries. In writing to the *Lancet*, as far back as 1874, after six years' experience of twisting, he tells that in a case of amputation of the forearm where all bleeding was arrested by torsion, except the interosseous artery, which he ligatured with gut, secondary hemorrhage occurred on the sixth day; the flaps were opened, when the bleeding was seen to come from the vessel that had been tied. He adds: "This is the only case of secondary hemorrhage from a stump which has occurred to me since I began

the practice of torsion in 1868, and it is interesting to know that it came from an artery that had been ligatured, and that the ligature was carbolized gut. . . . We have now had at Guy's Hospital 200 cases of thigh, leg, arm and forearm amputations, in which all arteries have been twisted, 110 of these have been of the femoral artery, and no case of secondary hemorrhage." It is important to add that torsion still holds out at Guy's for all vessels up to the femoral. The vessel to be secured should be separated from its sheath, and "twisted till resistance is no longer felt." It is needless to add that torsion is practised by other eminent surgeons in all countries to the exclusion of the ligature.

The next important point is accurate coaptation of the edges of the wound. Without this, healing by first intention is impossible, no matter how well other details have been carried out. In amputations, especially, it is necessary to exercise deliberation in constructing the flaps, otherwise proper coaptation may be impossible. The wound being closed, it is covered with an elastic pad of absorbent cotton, which has been impregnated with some disinfectant, and secured by the light pressure of a bandage. A drainage tube should be inserted at the lowest angle, if suppuration is deemed inevitable from the nature of the case. A wound thus treated is almost certain to do well. The main points to be careful about are: cleanliness, disinfection, arrest of hemorrhage, accurate coaptation, and, finally, a light, *dry* dressing. All surgeons insist on the wound being kept dry, for the evident reason that moisture and heat are essential elements in decomposition. A wound properly dressed should not be disturbed for four days, unless absolutely necessary. Needless and meddlesome interference only serves to retard the healing process.

The admirable results obtained by this mode of treatment, or some modification of it, have in no small degree stimulated and emboldened the surgeons of the present day, and led them to exercise a freedom with joints, the abdomen, and the different organs, never before ventured, and that, too, with the most surprising success. While it belongs to the few to go to these astounding depths and heights, it is the duty and privilege of all who use the scalpel at all to avail themselves of approved methods, even if it be but to close a wound already made or amputate a finger.

POPULAR GULLIBILITY.

It would be natural to suppose that in this age of what is called the universal spread of knowledge, the public generally would be comparatively free from the possibility of being taken in by the ignorant charlatan. Such is, however, unfortunately by no means the case. On the contrary, this very spread of knowledge, by giving rise to new and sensational theories, seems to have a peculiar tendency to mystify and mislead.

We have been lately particularly impressed with this by recent popular expositions of the so-called science of phrenology. Phrenology, every intelligent person knows very well, if it step beyond its legitimate sphere, viz., the observation of the general configuration of the skull, and attempts to dogmatize from supposed protuberances—popularly known as bumps—is simply an absurd hoax. Yet we find persons who go about the country and earn a magnificent livelihood by publicly giving utterance to the most palpable falsehoods concerning these said bumps, and actually asserting that they are able, from them, to read character. For ourselves we see no difference between such men and the common fortune-telling gypsy. Nevertheless, it is impossible to take them to task; if the public are willing to pay their fifty cents to hear how "manhood is analysed and restored;" and five dollars to hear what line of life they should adopt, and what sort of wives and husbands they should marry, we are powerless to blame those who cater to such deplorable ignorance.

Yet there is a remedy. To us, as medical men, this is of no little import. Phrenology, as taught by the class of men to whom we have alluded, is closely allied to branches of learning which come under our special protection. It is our duty to discover means by which to eradicate, or even to make impossible, the spread of these erroneous opinions. There are various ways of doing this. But we must follow the example of these persons to this extent: our exposition of these degraded sciences must be made fully as interesting as theirs. And it is quite possible to do so—indeed, in the hands of a skilful lecturer the charlatan could be held up to merciless and ludicrous criticism. We are glad to see that the press has treated this subject properly. Let us not be behindhand in doing our best to trample down scientific falsehoods of every description.

TREATMENT OF SYPHILITIC LESIONS.

Dr. Seguin published an article in the October number of the "Archives of Medicine," on the use of iodide of potassium in large doses for the relief of the later lesions of syphilis, particularly of the nervous system. He dwells at length on the authorities regarding the dosage of the iodides. Dr. Seguin states—and states correctly, too—that text-books are generally silent on the use of iodides in extremely large doses. He also claims that the practice originated in America. Dr. William H. Van Buren was the first to give potassium iodide in very large doses, and as the results of experience showed its advantage it has been used by others in the same way. Drs. William H. Draper, R. W. Taylor, W. A. Hammond, and others have taught the use of iodide of potassium in large doses for many years, but as a rule it has not been so used until within a short time. All cases of syphilis do not require very heroic treatment. When there is no immediate danger, doses of from twenty to thirty grains three times a day may be given to commence with. In the meantime the effects can be watched, as a few individuals cannot tolerate large doses. In syphilitic manifestations of the nervous system, such as convulsions, hemiplegia, coma, etc., it should be given in the very largest doses at once. Dr. Seguin recommends it in such cases in doses varying from two-and-a-half to ten drachms in twenty-four hours; he gives it before meals, largely diluted. We are pleased with the forcible manner in which Dr. Seguin has drawn attention to this important matter of treating syphilis in the tertiary stage. We have had considerable experience with iodide of potassium in the treatment of syphilis, and have given large doses of the iodides, but have never pushed the remedy to the extent that Dr. Seguin advises. We have usually administered it after meals and not before, as advised by Dr. Seguin. We have never produced iodism to any extent, nor have we observed any gastro-intestinal irritation. In some cases the addition of small doses of mercury may be made with advantage in the treatment.

AN ENQUIRY COLUMN.

It may not be generally known that there is published in England a magazine called *Notes and*

Queries, a very large portion of which is devoted to questions sent in letter-form from subscribers and others on literary, historical, archæological, and other subjects, which are answered in the same form by other readers.

The London *Lancet* has for many years devoted several pages of small print to notes, short comments, and answers to correspondents. This space has been well patronized, which is the best evidence we could have of its value to the profession. Medicine above all other sciences is benefited by the free communication and interchange of ideas among its votaries, and the medical press could thus greatly advance the interests and increase the sum total of knowledge amongst the large body of medical practitioners and students. Apart from the questions discussed by medical societies, and apart from the subjects treated of in papers contributed to medical journals, there are continually cropping up isolated problems which, although in reality often of vast importance, yet cannot be brought within the scope of either of the methods above mentioned. These could be laid open for the consideration and judgment of the profession at large by such a plan as we have referred to, and which it is our intention to adopt. To the student of medicine and junior practitioner it would be a great boon. The junior members of the profession are constantly meeting with difficulties which they cannot solve. Yet many of these difficulties could be tersely discussed through the press by such members of the profession as have the time and the opportunities to devote themselves to lending their aid in increasing the knowledge of medicine besides attending to their regular professional duties. Diagnosis and treatment are not the sole end of the life of a medical practitioner, and this system of notes and queries would tend to extricate many of our medical men from the monotonous groove into which too many of them have fallen.

We invite readers to send us for our March issue a few queries, worded as briefly as possible, on which we shall hope to obtain comments and answers for the succeeding number.

PROFFSSIONAL ADVERTISING.

Those of our readers who are not in the habit of perusing English papers will be startled to hear

that the supposedly immaculate British physician has betaken himself to advertising. How hath the mighty fallen! Yet so it is. In the London *Times* of December 19th an "F.R.S." sets the ball rolling by describing how "Dr. Hughes Bennett, under whose care the patient was, guided by Ferrier's experiments, skilfully interpreted the palsies and convulsive movements which the man exhibited, and deduced from them that a small tumor was lodged at one particular point in his 'dome of thought,' and was silently and relentlessly eating its way into surrounding tissues, . . . Very brilliant diagnosis this." He goes on to tell in the same graphic and dramatic way how "Dr. Godlee, surgeon to University College Hospital," excised the said tumor.

This sets the whole profession agog apparently, for in a few days the editor of the *Times* is inundated with letters. Dr. "Charles Egerton Jennings, M.S., M.B., F.R.C.S., Eng.," tells how the Vivisection Act "has delayed his own experiments on two subjects, both of considerable importance as tending to save human life when in urgent peril," and proceeds to inform the public that "in 1883 he devised a plan" by which transfusion of blood could be performed without danger. "John H. Clarke, M.D.," also rushes into a criticism of "F.R.S." And so it goes on; and all this hung on the slender peg of a revival of the agitation against the obstacles to vivisection.

We on this side of the Atlantic cannot pretend to be without sin, in view of the highly sensational items that appear in our local papers from time to time, an even quite recently, yet if this goes much further we may feel sufficiently stainless to cast a stone or two.

MEDICAL STUDENTS ANNUAL DINNER.—The medical students of McGill Medical College, Montreal, held their annual dinner on the 4th of December. The members of the Faculty, University officials and a large number of distinguished guests were present. Delegates were also present from the medical schools of Toronto, Kingston, and Montreal. The speeches were appropriate and eloquent, the programme excellent, and the entertainment most successful.

The annual dinner of the medical students of the Kingston Medical College was held on the

11th of December, and was a most successful gathering. Representatives were present from the medical schools in Toronto and Montreal, besides a large number of graduates and friends of the college.

The second annual dinner of the students of the Medical College in Winnipeg, Man., was held on the 19th of December, and was a great success. Speech, song and sentiment were the order of the evening, and a very pleasant time was spent by all.

TREATMENT OF TUBERCULOSIS.—Our foreign exchanges have had a good deal to say recently regarding the treatment of phthisis. R. Shingleton Smith, M.D., London (*Brit. Med. Journal*), read a paper at the meeting of the International Medical Congress at Copenhagen, in which he strongly advocated the use of iodoform in tuberculosis. He commences with small doses—one to two grains every four or five hours—and gradually increases the quantity till four to six grains and even more are given.

PELLETIERINE IN TAPE WORM.—Dr. Wilfert of Cincinnati, has been experimenting with pelletierine in the treatment of tape worm, and reports the result in the *Lancet and Clinic*, Dec. 27th. This remedy is an alkaloid obtained from pomegranate. The dose is from four to fifteen grains, and should be combined with an ounce of tincture of jalap, or the latter administered a short time afterwards. The results in Dr. Wilfert's practice have been most encouraging.

GASTROTOMY FOR EXTRA-UTERINE PREGNANCY.—In the *LANCET* for January 3rd, 1885, will be found a report of two cases of gastrotomy for extra-uterine pregnancy by Dr. James Braithwaite, of Leeds. Both patients recovered. In each case the placenta was apparently attached to the abdominal walls, and was left to slough off and escape through the lower part of the abdominal incision. This was accomplished in about three weeks.

MALTINE LABORATORY BURNED DOWN.—The laboratory of the well known firm of Reed & Carnrick was recently completely destroyed by fire, involving a heavy loss to the owners. New buildings have been secured, and the machinery for the manufacture of maltine is being rapidly put up, so that they will soon be able to fill orders for their specialties as usual. Peptonized cod-liver oil and

milk, one of their later specialties, though not long before the profession, already occupies a prominent place among preparations of its kind. It contains 52 per cent. pure oil, and being peptonized in combination with the milk is easily assimilated. It is very palatable; the taste of the oil is well disguised, and it agrees, as a rule, with the most delicate stomach.

COCAINE IN LITHOTRITY AND RECTAL SUGERY.

—An operation for rapid lithotrity was recently performed at St. Peter's Hospital, London, (*Lancet*) under muriate of cocaine, with perfect success, and entirely free from pain. The bladder was injected with half an ounce of a 4 per cent. solution of cocaine. Bettelheim, of Vienna, reports a case of enlargement of the prostate in a patient 74 years of age who complained much of rectal and vesical tenesmus. A suppository of cocoa butter containing half a grain of cocaine was introduced into the rectum at bed-time, and relief was obtained during the night and the following day. This was repeated when required and always afforded relief. This remedy is also used in the London Hospitals in the treatment of piles, fissure and fistula with excellent results.

ONTARIO MEDICAL COUNCIL.—We observe that

some anonymous scribbler has written two or three letters to the Toronto press advocating the doing away with the Medical Council. It is not our custom to notice the effusions of anonymous contributors, and we shall not depart from a well established rule in this case, further than to say that we trust no member of the profession in Ontario will allow himself to be influenced by such erratic nonsense as appeared over the signature of M.C.P.S.O. The profession of Ontario will be very foolish if it ever allow the management of its own affairs to be handed over to the senate of any University however powerful or popular it may be for the time being. There is no prospect of more than a *quasi* or partial federation of the colleges at best, and even if it were an accomplished fact in the fullest sense, that is no reason why the profession of Ontario should, of its own action, yield up any of its privileges or delegate its most important functions to a non-professional body. We will never consent to that.

NEW REMEDY FOR CANCER.—Another new re-

medy for cancer has been recently investigated. It is a Brazilian plant named *alvêloz* belonging to the euphorbiacæ. It has been used in the hospitals in Brazil, it is said, with success in several cases. From the reports which so far have reached us, however, it appears to be of value only in the treatment of epithelioma.

MONTREAL CARNIVAL.—One of the most noticeable features of the Montreal Winter Carnival is the magnificent special "Carnival Numbers," issued by Montreal publishers. Messrs. Dougall & Son, of the Montreal *Witness*, have issued an excellent number, teeming with illustrations, and having a gigantic four-page picture—"Storming of the Ice Castle by Night"—designed by Mr. R. Harris, A.R.C.A. Besides this there are full page pictures by Messrs. Bird, Raphael, Walker, and other Canadian artists, and the number also contains the Carnival Poem, appropriately illustrated, for which a prize of \$100 has been paid, and a special Supplement representing the various athletic clubs and their leading men. The letterpress pages have been tastefully prepared, and contain a very large number of engravings, representing various phases of our Canadian winter sports. The price is ten cents per copy, postpaid.

EXCISION OF A TUMOR OF THE BRAIN.—The sequel of the case of excision of brain tumor reported in our last number has unfortunately terminated in the death of the patient. Hernia cerebri supervened, but the cause of death was meningitis which extended to the base of the brain. The brain was otherwise practically normal.

APPOINTMENTS.—Dr. H. V. Ogden (McGill), has been appointed Prof. of Materia Medica in the Milwaukee Medical College, Wisconsin.

The following gentlemen have been appointed commissioners under the Liquor License Act: Drs. J. S. Sprague, of Stirling, and J. S. Loomis, of Madoc, Ont., for the Co. Hastings; Dr. A. Rockwell, for Hastings, W., and Dr. A. McLean, for Lambton, W.,

ARSENIC IN TUBERCULOUS DISEASE OF JOINTS.

—Arsenic in the form of Fowler's solution is highly recommended for tuberculous disease of the joints, especially when the disease is of long standing and the patient debilitated by suppuration. It is given in combination with cod-liver oil.

REMOVAL.—S. F. Wilson, M. A., M. D., C. M. (McGill), has removed from Berwick to Sussex, where he has become associated in partnership with Hon. Dr. Vail. Dr. Wilson leaves a host of friends at Berwick to regret his departure from their midst.

Dr. Darling, Prof. of Anatomy in the University of New York, died on the 25th of December, '84, at the advanced age of 82 years.

The death of Dr. Mahomed, at the early age of 35 years, is announced in our British exchanges.

Prof. Jaeger, of Vienna, the celebrated oculist died recently at the age of 77 years.

We regret to notice the sudden death of Mrs. G. O'Reilly, relict of the late Dr. O'Reilly, Hamilton. Three of her sons are members of the medical profession, Dr. Charles O'Reilly, Medical Supt. Toronto General Hospital, Dr. Gerald O'Reilly, Fergus, Ont., and Dr. Ed. O'Reilly, *S.S. Peruvian*.

BROMIDE OF ARSENIC IN PIMPLES.—It is stated on the authority of Dr. Piffard of New York, that bromide of arsenic is a cure for pimples. The dose is one to two minims of a one per cent. solution three times a day.

BRANTFORD HOSPITAL.—The "Stratford" Hospital, Brantford, will be formally opened by the Lieut.-Governor on the 10th inst. The Governors for 1885 are J. H. Stratford, Dr. Digby, Mayor Scarfe, Dr. Harris and Ald. Heyd.

BRITISH DIPLOMAS.—It affords us much pleasure to state that Dr. R. J. B. Howard, son of Dr. R. P. Howard, of Montreal, has recently obtained the F.R.C.S., Eng.

CHANGE OF ADDRESS.—The manufacturers of the Tucker Truss have removed from 123 Church Street to 274 Yonge, E. A. Smith's late address. See advt.

The Queen has appointed Prescott Hewitt, Bart., F.R.S., Sergeant-Surgeon in ordinary in place of the late Mr. Hawkins.

Dr. Sullivan, of Kingston, has been made a life senator of the Dominion of Canada. We congratulate our worthy confrère upon his appointment.

CORONER.—Dr. J. O. McGregor, of Waterdown, has been appointed Coroner for the Co. Wentworth.

Books and Pamphlets.

THE POPULAR SCIENCE MONTHLY FOR JANUARY, 1885. New York: D. Appleton & Company. Fifty cents a number, \$5 a year.

The January number of "The Popular Science Monthly" teems with thoughtful and practical articles. The first is "A Glance at the Jury System," by C. H. Stephens, who makes the defects of the system very evident, and shows that it was not established as a bulwark of popular liberty. In "Agnostic Metaphysics," by Frederic Harrison, "Last Words about Agnosticism," by Herbert Spencer, the religious discussion by these able thinkers may be said to be closed, for Mr. Spencer states that he shall say no more. "Influences determining Sex" by Prof. W. K. Brooks gives the results of a curious scientific research. The story of Tyndal's student-life, told by himself, under the title "My Schools and Schoomasters," will be eagerly read. "Studying Germany," by Horace M. Kennedy, contains valuable information for American students. J. H. Pooley, M.D., describes that curious affection, "Bloody Sweat"; W. M. Williams writes on "Condiments" and "The Cookery of Wine"; and "Protective Mimicry in Marine Life," by Dr. W. Breitenbach; "The Advantages of Limited Museums," O. W. Collet; "The Architecture of Town-Houses," by R. W. Edis F.S.A.; and "Mountain Observatories," are all valuable articles. The subject of the portrait and sketch is that eminent chemist Sir Henry Roscoe.

DISEASES OF WOMEN, by H. MacNaughton Jones, M.D., F.R.C.S.I. & E. New York: W. Wood & Co. Toronto: Williamson & Co.

Those who desire to obtain, at a minimum cost of time and money, a better acquaintance than the present educational facilities of this country present to the aspirants for gynæcological celebrity, will find in this work of Dr. Jones, conveyed in clear and plain terms, if not all that the modern infinitude of female diseases may seem to demand, yet perhaps sufficient to serve their more pressing needs, not only in the line of positive instruction, but also in that which is not less useful to the ambitious neophyte,—salutary admonition. To the admirers of the gynæcological *armamentarium* the 180 well executed plates contained in the book, must give it an attractive prestige, whilst to the

budding specialist they may prove profitably deterrent, until his finances may enable him to procure a more complete gynæcological equipment.

HENKE'S ATLAS OF SURGICAL ANATOMY—A SERIES OF PLATES ILLUSTRATING THE APPLICATION OF ANATOMY TO MEDICINE AND SURGERY—Translated by H. A. Rochester, M.D., Lecturer on Pathological Anatomy, Miami Medical College, Cincinnati: A. E. Welde & Co., 1884.

This fine volume reflects credit on the enterprise of the publishers. It contains eighty-one plates, which have been executed with rare skill. These plates may be regarded as a supplement to any text-book of anatomy or any atlas of descriptive anatomy, filling the niche which they have left vacant. They will be valuable to students and practitioners. To the former as a means of fixing in their minds the lessons learned in dissection: to the latter accurate pictures are presented of the connections and relations of the viscera, as well as of the appearance of parts, just as they are exposed by the surgeon during operations. The price at which it is offered is very low (\$10). This work ought to command a large sale.

ADAMS' HISTORICAL CHART; with Maps of the World's Great Empires. New York:—Colby & Co., 5 Union Square.

The object of Adams' Chart is to picture history, and to so arrange and tabulate the subjects of history that men, events, and nations, may be located in time by being seen in their positions on the charts as the school atlas locates places. To accomplish this, the chart is divided by perpendicular lines into the 59 centuries and their decades, and colored lines passing from left to right represent different nations, change of rulership being indicated by change of color. The rise, progress, and fall of nations are prominent features in the chart. The plan is so simple that children can readily understand it, and so comprehensive that it is in itself an historical cyclopædia for the mature scholar. An explanatory key accompanies the chart. It is published in three forms, on rollers, portfolio, and book form. Price from \$10 to \$15.

THE MONTREAL DAILY STAR.—Carnival number, 1885. Montreal: Graham & Co. Price, 15cts.

This is a highly creditable production, and is in great demand. It contains besides choice reading matter, beautiful colored plates of the various

carnival scenes both real and imaginary; the allegorical representation of the carnival; the skating carnival representing the various costumes worn; the "Tandem Club" turn out; the ice lion, and the ice condora; representative ancient and modern houses in Montreal; tobogganing slides; the ice palace; the politicians at the carnival; storming the ice palace; snow shoe club, etc. etc. It is one of the best productions of its kind ever printed in Canada, and reflects no small credit upon the publishers.

THE LONDON MEDICAL STUDENT, AND OTHER COMICALITIES, selected and compiled by Hugo Erichsen, M.D., author of Medical Rhymes. Published by Dr. H. Erichsen, 11 Farmer St., Detroit, Mich. Price, \$2.00.

This interesting compilation is admirably adapted to instruct and amuse the busy practitioner in his leisure moments, or while waiting on the sometimes slow process of nature in the lying-in room. The London Student was originally published in *Punch* half a century ago, and the authorship was variously assigned to Hood, Dickens, Thackeray, Mark Lemon and Douglas Jerrold. It is a very amusing satire on medical student life in those days. A number of amusing anecdotes chiefly of a medical character complete the volume.

MANUAL OF ORGANIC MATERIA MEDICA, for the use of Students, Druggists, Pharmacists, and Physicians, by J. M. Maisch, Phar. and Prof. of Materia Medica in the Philadelphia College of Pharmacy. Second edition, with 240 illustrations. Philadelphia: Lea, Bros. & Co. Toronto: Williamson & Co.

The author is well known as the joint author of the *National Dispensatory*, and the work may be regarded as a companion to the Dispensatory. It is adapted for the use of students as an aid in systematic instruction, filling a position which could not be done by the larger work. The author gives in a concise form the *essential* physical, histological, and chemical characters of organic drugs. The classification, which is according to the origin of the drug, is the author's, and while he is "conscious of its imperfections believes it to be convenient and capable of practical application."

MICRO-ORGANISMS AND DISEASES, by E. Klein, M.D., F.R.S., New York: McMillan & Co. Toronto: Williamson & Co.

This is a valuable little work which must prove

very useful to those who desire to acquire an introductory knowledge of the important subjects treated of in it. The work is a small octavo of 191 pages, in small but neat type. It contains no less than 108 illustrative plates, which must materially aid the reader in his study of this interesting and useful department of modern medicine.

THE BASIC PATHOLOGY AND SPECIFIC TREATMENT OF DIPHTHERIA, TYPHOID, ZYMOTIC, SEPTIC, SCORBUTIC AND PUTRESCENT DISEASES generally, by George I. Ziegler, M.D. Philadelphia, G. I. Ziegler. Toronto: Williamson & Co. Price, \$2.00.

This work contains a general summary of the basic pathology and specific treatment of the above diseases from the author's point of view, viz: the pathogenic factor, ammonia engendered from within or introduced from without the economy. The work is very interesting and will well repay a careful perusal.

ELEMENTS OF PRACTICAL MEDICINE by Alfred H. Carter, M.D. New York: D. Appleton & Co. Toronto: Williamson & Co.

It is only necessary to mention in evidence of the high appreciation of this work by students preparing for final examination that within a comparatively short time a third edition has been called for. The work is compact and comprehensive, and will be useful as an aid, and convenient for reference, to students in attendance on lectures or clinics.

HOLDEN'S ANATOMY.—A Manual of Dissection of the Human Body, by Luther Holden, late President of the Royal College of Surgeons, England, etc. Fifth edition. Edited by John Langdon, Lecturer on Anatomy at St. Bartholomew's Hospital, etc. With over two hundred illustrations. Philadelphia: P. Blakiston, Son & Co. 1885. Toronto: Willing & Co.

This excellent work on practical Anatomy has many points of special merit to commend it as a manual of dissection. The descriptive part is concise and accurate, the relative situation of parts is made clear, and many valuable practical suggestions are thrown out here and there as to diseases and injuries which are liable to occur in the part under consideration. A number of new diagrams and illustrations are introduced in the present edition, and more space is given to the consideration of the anatomy of the nervous system.

THE PHYSICIAN'S POCKET DAY-BOOK, by C. Henri Leonard, M.A., M.D., Detroit, Mich., 1885.

This will be found a most admirably arranged companion to the practitioner. It differs from most of its kind in having no other matter except the daily record of business, obstetrical memoranda and miscellaneous accounts.

DRUGS AND MEDICINES OF NORTH AMERICA. A Quarterly Journal devoted to the botany, pharmacy, and therapeutics of the medical plants of this Continent. Cincinnati: J. & C. Lloyd.

We have received the first and second numbers of this interesting and practical Quarterly. The work is an entirely new venture, and has a wide field of usefulness before it.

TEXT-BOOK ON HYGIENE by Dr. George H. Rohé, Professor of Hygiene, College of Physicians and Surgeons, Baltimore. Toronto: Hart & Co.

The above work is an admirable compendium of Sanitary Science and well adapted for students.

MANUAL OF BANDAGING by C. Henri Leonard. Second Edition. Revised and Enlarged. Published by Illustrated Medical Journal Co., Detroit.

RELATION OF ANIMAL DISEASES TO THE PUBLIC HEALTH, and their Prevention, by Frank S. Billings, D.V.S. New York: D. Appleton & Co. Toronto: Hart & Co.

CONSUMPTION, its Nature, Causes, Prevention and Cure, by J. M. W. Kitchen, M.D., Assistant Physician to the Bellevue Hospital. New York: G. P. Putnam's Sons. Toronto: Hart & Co.

Births, Marriages and Deaths.

On the 23rd of December, 1874, Dr. J. W. Sparrow, of Teeterville, Ont., aged 45 years.

On the 20th December, 1884, Dr. J. McDowell, of Shawville, Que., aged 35 years.

On the 4th ult., at Port Arthur, Dr. Lorne C. Campbell, aged 35 years.

On the 13th ult., Dr. O. T. Heartwell, of Dunnville, Ont., aged 36 years.

*** The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

THE CANADA LANCET.

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Original Communications.

A CURIOUS CASE OF MALARIAL NEURALGIA.

BY F. KRAUSS, M.D., TORONTO.

Prof. Med. Jurisprudence Woman's Med. College.

On the 16th of March, 1884, I was sent for to attend Mrs. J. N—, æt. 33, who was suffering from a severe attack of neuralgia. The patient's appearance presented all the characteristics of the malarial cachexia; she was much emaciated, and her complexion was considerably jaundiced. The history of the case is a peculiar one. For three years previous to 1881 she had resided in different malarious districts in Michigan, but enjoyed complete immunity from malarial symptoms until April in the year mentioned, when she was prostrated by an attack of intermittent fever, which continued, with more or less severity, for three months, the paroxysms being quotidian. In the fall of the same year occurred the first of a series of periodic attacks of neuralgia which have since been maintained with unvarying regularity as to time of occurrence and succession of symptoms. Previously to her illness the woman had always enjoyed perfect health, was strong, vigorous, and active. Family history good.

The characteristics of the periodical neuralgic attacks—as described by the patient and her husband—are as follows: Each attack consists of a "period" of nine days, and occurs twice in the year—in the spring, about the time the snow is disappearing; and in the early winter just before the first appearance of the snow. The paroxysms are quotidian and retarding, that on the first day setting in about 8 a.m., and each successive one about an hour later than on the preceding day. They also gradually decrease in length of duration, usually terminating, no matter at what hour they begin, at about 9 or 10 p.m. The individual

paroxysms much resemble those of intermittent as to succession of events. Each is preceded by marked coldness of the extremities, especially the feet; the other symptoms of the prodromic stage are wanting. Anorexia is persistent throughout the entire period; no vomiting. Violent throbbing, referred to the back of the right orbital cavity follows, and ushers in the cold stage. The latter only differs from the same stage of intermittent in the co-existence of neuralgia. The throbbing behind the right orbit is intensified by excruciating lancinating pain in the same situation, and, in a less degree, along the course of the right supra-orbital nerve. There is also a sense of tension and pressure behind the globus, and which the patient describes as being such as might be occasioned by the presence of an abscess. The whole region about the affected eye is tender; much photophobia exists, with redness of the conjunctiva, and a copious flow of watery fluid from the eye, which the patient declares excoriates the skin of the cheek. Movements of the orbit are attended by a grating sensation. The other eye is unaffected. During this stage the patient maintains an erect sitting posture and complains of a sensation of great distension in the head. Pain in the frontal sinuses precedes, accompanies, and succeeds the cold stage; there is no præcordial oppression. The pain during each paroxysm is remittent, each access being limited to three or four minutes and rapidly followed by another, the entire stage lasting from half an hour to an hour. The hot stage now supervenes, with a cessation of the neuralgic pain and the throbbing, only a feeling of soreness and tenderness remaining. In an hour or two the pyrexia abates, and the sweating stage sets in. The patient, utterly exhausted, falls asleep, and usually sleeps until morning.

The above succession of symptoms is repeated daily—but commencing each day at a later hour—until the ninth day, when a curious phenomenon is described as invariably occurring. The upper eyelid on the affected side becomes ecchymosed, and during or after the sweating stage the patient experiences "a cracking sensation, as if something had given way," at the chief seat of pain, accompanied by immediate and sudden relief from the feeling of tension and pressure. In her own words, "an abscess seems to burst," and she insists that a discharge of pus into the pharynx takes place.

She is now free of her enemy for the next six months, although, since the occurrence of the first neuralgic manifestations she has had frequent intercurrent attacks of true intermittent, more especially during her residence in a malarious district. In 1883 she and her husband removed to Canada—first to Hamilton and then to Toronto—and since that time she has had two attacks of true intermittent, one following the death of a favorite child. In every instance the ague was quotidian, the paroxysms beginning about 7 p.m. For a month after each neuralgic attack the patient suffers more or less from dull pain about the eye, asthenopia and tenderness of the scalp; a herpetic eruption makes its appearance about the lower lip, and desquamation of the cuticle occurs over the greater part of the surface of the body. Shortly before each neuralgic period the face assumes a deep lemon hue, but this disappears a week or two afterwards. The urine is at all times high colored, and during the neuralgic periods is deeply tinged with bile. The patient can prognosticate the approach of a semi-annual attack by the occurrence of vertigo on stooping, and by the appearance of the yellow tinge over the face.

Variations of the phenomena described have been noticed on two or three occasions. Thus, in the fall of 1882, the period came on after the patient had contracted a severe cold, and lasted ten days, with the usual retarding paroxysm on each. In no other instance has the duration exceeded nine days. In the spring of 1883 the neuralgia, for the first and only time, was seated in the left eye, the right being unaffected. The phenomena which manifested themselves on previous occasions, when the right eye was the seat of pain, were exactly repeated on the left side—including those indicating the termination of the period—but with the addition of a purulent discharge from the left ear—the only occasion on which this has been observed. In the fall of 1883 there was no well-marked period; some fever and a sense of fulness in the head occurred at the usual time, but disappeared three or four days later. There were no chills whatever. The contrast between this incomplete attack and the fully developed periods, in which the chills are the marked feature, is strikingly suggestive of that between the so-called “dumb ague” and intermittent of the “shaking” type. A still more curious variation is noted fur-

ther on as occurring during the period which came under my own observation. The patient has also noticed that with each recurrence of the semi-annual attack the pain in the orbital cavity appears to extend further backwards. After the first neuralgic attack, in the fall of 1881—for which the patient was treated in Michigan—onychia developed, first on the right then on the left hand, with subsequent shedding of all the nails; there was much salivation; the enamel scaled from the teeth, especially the molars and bicusps; the teeth were loosened and later on broke off at the neck, without any appearance of caries. There was also considerable cedema of the lower extremities. The patient and her friends attribute these occurrences to the drug employed, and which, I am given to understand, was administered by “a sort of horse-doctor.” It is described as a white powder, with a slightly sweetish taste. Although only half the quantity prescribed was taken (at bedtime), violent delirium set in and lasted throughout the night. The symptoms just detailed followed a few days later. The toxicologist will be inclined to regret the fact that the further services of the horse-doctor were dispensed with.

I saw the patient for the first time at 4.30 p.m. on the 16th of March, the third day of the period. On the first day, the 14th, the attack had commenced at 8 a.m., and was ushered in by the usual coldness of the extremities, and—a symptom hitherto not experienced and not since repeated—neuralgic pains down the back of the neck and along the whole length of the spine. The other symptoms as usual. The second paroxysm, on the 15th, had commenced at 9 a.m., and was less violent than its predecessor. On the 16th the paroxysm did not occur until 1 p.m., and when seen the patient was in the sweating stage. An examination revealed an anæmic murmur in the vessels of the neck, and the palpebral conjunctiva was found to be almost colourless; the face of a deep lemon tint, the skin on the affected side—the right—unnaturally dry, and the hair, especially on the right side of the head and about the right temple, turning grey; tongue slightly coated; bowels regular. In the hope of witnessing a paroxysm, and thus being able to verify the patient's statements, I postponed treatment.

March 17.—At 3 p.m. no marked paroxysm had occurred, though the patient had suffered during

the morning from feverishness and sense of fulness in the head. Both this and yesterday morning she experienced "a trickling sensation" in the upper and back part of the nose, followed by the discharge of a few drops of blood from the left nostril, which appeared to give immediate relief. This had never occurred before she said. Pulse, when seen, 80; temperature 99°. Ordered the following mixture:—

R. Quin. Sulph ℥. ij,
 Acid hydrobromic ℥. ss,
 Extr. gelsemii fl. m. xl,
 Ol. caryophylli. m. vj,
 Elixir. adjuvantis (Caswell &
 Hazard) ℥. iv,
 Aq. ad ℥. viij.—M.
 Sig.—℥. j. o. h. 4 t̄a sum.

March 18.—Saw patient at noon. Marked cinchonism; no paroxysm so far; she says the pain "is there, but the medicine is holding it back." Ordered half doses of the quinine mixture. On calling again at 4.30 p.m. found the patient in the height of a paroxysm, being the third since I had left her shortly after noon. The first of these occurred about 1 p.m., the second about 2.30, and the third at 4. This last was described as the most severe yet experienced. When seen the patient was in the cold stage; pulse 88, temperature 99½; unable to lie down; great photophobia; pupils dilated, although she has taken half a grain of morphia *per orem* in divided doses since one o'clock. In addition to the intense pain behind the right orbit there was a constant dull pain in the frontal sinuses and across the interorbital space. No pain whatever below the level of the floor of the orbital cavity. Action of the rectus internus and obliquus superior induced acute pain; that of the rectus externus and obliquus inferior some pain, but of a less severe character; contraction of rectus superior gave rise merely to a slight "pricking" sensation; while that of the rectus inferior was unaccompanied by pain or uneasiness. No discharge of watery fluid from the eye, nor redness of the conjunctiva; no *bruit* on auscultating the temple or globus. Pressure on the right temple seemed to give relief, and was repeatedly asked for. Tremor, mainly confined to the lower jaw. For a few moments the patient appeared to be delirious; she declared her head was a balloon and was sailing out of the room, and at the same time craned her

body forwards as if compelled to follow it. Also complained of neuralgic pains in the stomach. Gave morph. sulph. gr. ¼ hypodermically; pain soon after subsided and the patient fell into a dose. Half an hour later her pulse was 84, temperature 99°; pupils still dilated.

March 19.—At 4 p.m. pulse 84; temperature 99½. No paroxysm to-day; slight feverishness early in the afternoon. Patient complains only of slight headache and the usual symptoms of cinchonism. Vomited this morning, food and mucus, streaked with blood. No pain elicited on pressing on the teeth. Continued the quinine, gr. ijss. every four hours without the gelsemium.

March 20.—Vomited again this morning as before. A little feverishness about noon; chilly sensations with slight throbbing behind the orbit at 3 p.m., but when seen at 4 p.m. this had nearly disappeared. Pulse 104; temperature 99½. Eruption beginning to make its appearance about lower lip. Another slight access of fever at 6 p.m. No paroxysm proper during the day.

March 21.—Patient in a state of extreme nervous depression owing to an accident to her son. At 5 p.m. pulse 96, almost imperceptible; temperature 98½. Complained of "pains in all her bones."

Thenceforth the patient made a rapid recovery, without the appearance of any of the phenomena described as attending the close of the period. She was put upon quinine and iron (Vallet's mass), to be continued until the usual time of the fall period should have passed. Early in May she was doing well and looking more healthy, and I have not seen her since.

BORO-GLYCERIDE IN THE TREATMENT OF SUPPURATIVE DISEASES OF THE MIDDLE EAR.*

BY A. M. ROSEBRUGH, M. D., TORONTO.

Boracic acid and glycerine, when heated, combine to form a new substance, namely, boracic glycerine or boroglyceride. The proportion is according to their atomic weights boracic acid 62 parts, and glycerine 92 parts. They are gently heated over a water bath. The boracic acid is gradually added to the glycerine, and the heat con-

* Read before the Ontario Med. Association, June, 1884.

tinued until 54 parts, or 3 molecules of water, are driven off. The boroglyceride "on cooling is an amber colored vitreous mass, which is very friable and easily broken. It is readily soluble in glycerine, but less so in hot or cold water (about 10 per cent)." "It has an acid, pungent taste, and an astringent effect when applied to mucous membranes."

This new substance or compound is an antiseptic, and if we mistake not is determined to play an important rôle in the antiseptic surgery of the near future.

I believe it was the great author of antiseptics, Prof. Lister himself, who first suggested that suppurative diseases of the middle ear should be treated antiseptically. An antiseptic dressing, in order to be effective, must insure two important conditions, namely, complete exclusion of the air, and perfect disinfection of the whole suppurating surface.

In otorrhœa, where the drum cavity communicates with the external auditory canal, by means of a perforation of the drum membrane, it would seem, at first sight, to be impossible to secure these conditions. Stimulated however by the success of antiseptics in general surgery, the profession long since commenced the use of antiseptic solutions and powders in the treatment of purulent middle ear diseases, but with only partial success. Weak solutions of carbolic acid ($\frac{1}{2}$ to 1 per cent.) were found to be useful for cleansing in cases of caries or necrosis of the bone, but it caused an increase in the secretion and a more swollen condition of the tympanic mucous membrane. Salicylic acid in alcoholic solution was used in chronic cases, but it was not well borne in acute cases. Iodoform, either alone or combined with other powders, as alum or oxide of zinc, has also been extensively used, but many object to it on account of the smell.

In 1879 Prof. Bezold, of Munich, commenced the use of boracic acid in the treatment both of acute and chronic cases of suppurative inflammation of the tympanic cavity, and with most encouraging results. He reported in that year 145 cases that had been treated with the boracic acid—29 with acute, and 116 with chronic suppuration. Of the acute cases, the average duration of the discharge was only 13 days; and of the chronic cases the average duration of the treatment, until all discharges ceased, was only 19 days.

After trying saturated solutions of boracic acid, and getting no better results than were obtained from other antiseptics, he tried filling the meatus with very finely pulverised boracic acid, and with the result as just reported.

"He asserts that this method of treatment is so much more certain, and so much quicker than other methods, that he now uses it in every case of suppurative disease, either of the meatus or tympanum, and also after lesser operations, such as the removal of polypoid granulations, cauterization and paracentesis; he excepts, however, extensive disease of the bone and perforation of the mastoid. He does not consider that it supplants, but rather assists other methods of treatment, like the antiseptic dressing in surgery; cauterization of granulations, removal of polypi, etc., are still as necessary as ever."

"The meatus and tympanum are first cleansed carefully with a four per cent. solution of the acid, then dried thoroughly, and finely pulverized boracic acid blown in over the suppurating surface; the meatus is then closed with salicylic, carbolic or boracic cotton."

"The pulverized acid has the advantage of producing no re-action on the mucous membrane, of withdrawing the water from the membrane which keeps a saturated solution in contact with the inflamed surface, and of not forming coagulations with the secretions. In cases of otorrhea, complicated with phthisis of the lungs, the acid had no effect on the discharge." The use of the boracic acid powder, however, is attended with certain drawbacks. 1. Its application is somewhat inconvenient. 2. It retards the free exit of the discharges. 3. In some cases there is a tendency for the powder "to cake," which renders the thorough removal difficult. 4. It fails to completely remove the odor.

Boroglyceride is free from these objections. It removes the odor almost immediately, and is so easily applied, that in some cases the application may be entrusted to the patient. With its use I have also succeeded in causing granulation tissue to disappear without resorting to the use of chromic acid or the other caustics. It is used as follows: The ear is carefully syringed with a warm, almost hot, saturated solution of boracic acid. Politzer's air bag, or the eustachian catheter is used to force the discharge from the middle ear through the perforation into the external auditory canal. The syringe is again used, and the fundus of the meatus dried with borated cotton, attached to the end of a probe.

The ear mirror is now used, and, if necessary, the cotton used again and again until all the discharges are thoroughly removed. The head is bent to the opposite side, and the upturned ear is half filled with the warm solution of boroglyceride. While the head is in this position air is forced through the eustachian tube, middle ear and perforation, and through the column of medicated fluid. In addition to this the tragus is pressed backwards and inwards, so as to compress the air over the fluid. Both these procedures favor the passage of the boroglyceride into the middle ear. If the patient is unable to force the air through the eustachian tube—the catheter or the air douche is used. A plug of absorbent cotton, soaked in vaseline is used to prevent the boroglyceride from escaping. The patient is seen two or three times a week, and in the meantime the ear is to be syringed with the boracic acid solution, and the boroglyceride applied night and morning at home. The boroglyceride is used in solutions of glycerine varying in strength from 10 to 100 per cent. according to the case. Dr. R. C. Brandeis, of New York, who has been using this remedy for the last two years, commences the treatment with the more concentrated solutions, and diminishes the strength as the mucous membrane assumes a healthier condition, and as the discharge diminishes.

"This remedy, he states, has enabled him to discharge patients as cured in from three to four weeks, who, he is sure, under the old methods, would have been under treatment as many months.

With a view of making the history of boroglyceride more complete, I may add, that in March, 1882, Prof. Barff read a paper before the London Society of Arts, "On a New Antiseptic Compound and its Application to the Preservation of Food," etc. This paper was published in the *Journal of the Society*. In the *British Medical Journal* for April 29th, 1882, Mr. Balmanno Squire suggested that the new compound be given a trial in antiseptic surgery. This led Dr. Brandeis to use it in aural surgery, the result of which he reports in *The Archives of Otolaryngology* for April, 1884.

CHARCOT'S JOINT DISEASE.

BY C. L. COTTON M.D. COWANSVILLE, QUE.

GENTLEMEN.—As the subject of Charcot's joint disease has recently attracted a good deal of attention, I trust a few notes of a case, which I have under my observation, may prove of some interest to this meeting :

H. G., aged 42, a native of England; engaged in the dry goods business in New York during 14 years. He has a good family history; no case of

nervous disease that he can discover. He had convulsions when a child, but enjoyed generally good health until 1876 when he noticed strabismus of both eyes. He had one eye operated on in Glasgow and the second in Paris, since which time he has had no further trouble with his eyes. In looking back he can notice some failure in his gait in 1879, which was soon followed by neuralgic pains in his legs. These began quite suddenly. He can remember distinctly the place and hour when he had the first attack. He describes them as the usual pains of locomotor ataxia are described—as lightning-like pains. These have continued until the present, each attack lasting two or three days, and then an intermission of two or three weeks. He also had a cord-like feeling about his waist and a weakness in the knees.

He first came under my notice in December, 1879, when he presented very typical symptoms of locomotor ataxia. His walk was quite ataxic, could not stand with his eyes closed. Patellar reflex absent; complained severely of the feeling of girdle pains; some loss of power over the sphincters and diminished cutaneous sensibility in the legs. He continued in very much the same condition, but with a gradual failure of co-ordination until July, 1883, when one day while using a saw in such a manner that his right leg was put into a swinging motion over the edge of the box, the under surface of the thigh coming in contact with the box, he noticed immediately afterwards his knee very much swollen, and during the day the leg, foot and toes were involved in the swelling. There was a slight purple discoloration on the under surface of the thigh. My attention was called to it about ten days later; there having been no pain about it from the first, it had been looked upon as a simple sprain. I found the knee and leg as far as the ankle much swollen, the joint full of fluid and crackling on pressure. It had the appearance of a joint undergoing rapid disorganization. His present condition one year since the knee was first affected will be seen by the appearance of these photographs. The joint is enlarged; the lower end of the femur appearing to be much enlarged. There are no apparent bony outgrowths. Both bones of the leg are dislocated outwards, though they can be readily replaced, and in doing so give rise to a sound as if the ends of the bones were quite worn away. There is no fluid in the

*Read before the Canada Med. Association, August, 1884;

joint, no crackling feeling present. The veins are much enlarged over the knee. Both legs are much wasted; patellar and plantar reflexes absent; cutaneous sensation entirely absent in the feet, legs, and lower half of the trunk. He can support part of his weight on the diseased knee, but is afraid to do so; consequently he does not attempt to walk, but gets about comfortably in a wheeled chair. Appetite good. Digestion somewhat at fault, but generally fair. Sexual power lost during the last twelve months. The sphincters are weakened. At times he can control his bowels and bladder; at other times he finds it impossible to do so. Has never had gastric crises, and never felt any pain in the affected knee. Girdle pains have disappeared. In reference to the loss of sensation, it is curious to note that he has a large corn on one foot which often causes him severe pain. He complains of much numbness in his fingers.

The question of the relationship of joint affections occurring during the course of locomotor ataxia with the special lesion of the spine has been very freely discussed during the last few months, giving rise to papers at the clinical and pathological societies of London. Charcot, whose name has been associated with this disease, in his earlier observations attributed it to the anterior cornua of the spinal cord becoming involved in the diseased process. But further post mortems showed that the disease could be present without lesion of the anterior cornua being demonstrated. Dr. Buzzard is strongly inclined to the opinion that the pathological centre is to be found in the medulla oblongata and brings forward as an evidence the frequent presence of laryngeal, gastric and intestinal affections (more than 50 per cent.) associated with bone joint troubles. Sclerosis attacking the vagus centre is in short his theory. Thus far there has been no discovery of a joint centre in the nervous system, and it would seem that, with the close pathological study that has been given to "centres," if such a centre existed, the question would have been set at rest before this. Charcot depends chiefly on the clinical features and pathological changes in his assumption of this being a distinct specific arthropathy. Another view of the pathology of these cases is that they are an ordinary arthritis modified by the conditions of the patient. In support of this view are the very similar joint changes noticed after injuries to nerves. Weir Mitchell, Sir

Wm. Gull, Ziemssen and Charcot have all noticed cases of arthritis due to nerve lesions, and it is a question whether rheumatism has its origin in the nervous system. These lesions are usually ascribed to the inhibition of the trophic influence of certain nerves. The third view of the pathology of these joint cases is that they are ordinary rheumatic or other forms of arthritis occurring in ataxic patients independently of their nervous disease. My experience of these cases being limited to the one under discussion, I must leave the question of pathology to others who have had more experience. But I must observe the course of this case has been different from any joint affection that has come under my notice. The entire absence of pain, the rapid disorganization of the joint, with the history of a slight injury, would incline me to the view, that, firstly, there must have been a predisposition to joint affection, otherwise so slight an injury could not have caused such a serious effect; and secondly, that the trophic nerves, and I think that it is generally admitted that certain nerves have trophic influence, must have become seriously impaired in their function. If these joint affections occurring in locomotor ataxia are not specific arthropathies, and I do not think that this has yet been proved to a certainty, there is no question in my mind that they are strongly modified by the diseased nerve influence.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—I noticed in the last number of the LANCET a communication from Cornwallis, N.S., signed "A Resident Physician," directing attention to the want of medical ethics displayed by some of the fraternity in that locality. If the writer of that communication were to visit a small town, not far from the metropolis of Ontario, I could point out to him some specimens not to be excelled by the most astute thimble-riggers our friends by the sea could produce. The mode of operation adopted by the medical trickster, "down by the sea," does not indicate any great amount of shrewdness, and differs somewhat from that adopted by his species in this locality. He depends too much, I fear, upon himself and his "helpmeet." He should imitate his friend in the west, by forming a "petticoat brigade," with himself as head Beadle—

his "helpmeet" President, and his sister-in-law, should he chance to have one, as Vice, things could be worked nicely. The rank and file might be filled by the confidants of the president and vice. Thus arranged, if called to consult another physician, say in a case of confinement, he might whisper the assurance to his wife, or her sister that his timely presence had saved the friends of the patient an undertaker's bill. The president and vice could mention it cautiously, and, of course, quite casually to their lady confidants, and they, in turn, through the promptings of the president and vice, might be relied on to retail the news to the whole circle at the next afternoon "tea-party" they attended. In this way superiority and skill could be made known, and by a little indirect manoeuvring the whole female community might be let into the secret—especially that part of the community likely to prove of interest to the accoucheur. The Nova Scotian, like his brother chip in this part of the Dominion, might facilitate operations to some extent by taking in a partner. The partner needn't necessarily be gorged with medical lore. He would require to be a sort of "free and easy," and be stocked with a liberal amount of conceit. His usefulness would depend very much upon his cheek; his inability to take a rebuff, and upon his ability to fix up a plausible story. In order to prove a success he would require to force himself, in a social way, into the houses of other physicians' patients, and by a little hinting and winking endeavor to create an impression that the family physician had made some remark reflecting on some of the lady members of the family. He might, at the same time, do a little puffing on his own hook—give, say, in an indifferent sort of way, a synopsis of cases "placed specially under his care," and let the public know what gratitude is due to him by suffering humanity. There are a hundred and one other ways by which our Nova Scotian friend might become enhanced in the eyes of an unsuspecting public, and should he become cornered in a treacherous and dishonorable act, he will differ very much from those of his kidney here, if he don't throw dirt and call in the assistance of his tools and minions to cover his guilt. The fact is the slipshod, artful, half positive, half negative physician, is the same kind of an animal wherever you find him, varying only in the manner he may adopt, and the facilities he may possess for per-

forming his tricks. By all means let the Nova Scotia man have a chance, for, like his Ontario prototype, he may have only his tricks and shams, and "petticoat brigade" to depend on.

Yours, &c.,

A RESIDENT PRACTITIONER.

February 13th, 1885.

Selected Articles.

BONY UNION IN INTRACAPSULAR FRACTURE OF THE FEMORAL NECK.

Dr. John B. Roberts, of Philadelphia, read the following paper before the Philadelphia County Medical Society in November last:

Much has been said against the possibility of osseous repair occurring after intracapsular fractures of the neck of the thigh bone. It is probable that this teaching has induced more than two-thirds of the general medical profession to believe that bony union of such lesions never occurs. Careful investigation of cases and specimens by competent surgical observers has conclusively demonstrated that such belief is erroneous. Bony union does occur, though not frequently. In my opinion, moreover, its non-occurrence is to some extent due to the violent and unjustifiable manipulation to which injured hips are often subjected, by reason of the attendant's ignorant desire to demonstrate crepitus and preternatural mobility. The diagnosis can usually be made with reasonable certainty without the development of these symptoms of fracture. Therefore, it is unnecessary and improper to imperil the future usefulness of the limb merely to arrive at an absolute diagnosis. In cases of doubt it does no harm to treat the case as one of fracture, even if none exist; but violent manipulation, by tearing connecting bands of periosteum or detaching the impacted fragments, greatly reduces the probability of union.

Union *may* be bony and the function of the joint perfectly or almost perfectly restored; if not bony, the bond of union *may be* a very short, fibrous one, giving as good functional result as osseous repair. Hence, the surgeon should treat his cases as if he expected a good cure; for it is impossible to say that a given patient is one in which no attempt at union will take place. Non-union of intracapsular fracture of the hip is, it is true, often found. I have in mind now a case where the autopsy showed no attempt at even fibrous union. Let us not expect this, however, as a rule, for then we may be led to neglect proper therapeutic measures. Specimen No. 1130¹⁵ of the Pennsylvania Hospital Museum, taken from the patient referred to above, between eighteen and nineteen weeks after the in-

jury, is a good illustration of non-union. It was a transverse fracture at the junction of the head and neck of the bone. Specimen No 1130²⁰, from the same Museum, on the other hand, is here shown you; it is described in the Museum catalogue as an intracapsular fracture firmly united; and by longitudinal section shows bony union. The specimen belongs to Dr. T. G. Morton, and was removed from a patient, aged 67 years, twelve years after the accident that caused the injury. There is some evidence of impaction near the base of the neck; and it is perhaps possible that part of the line of fracture extended without the capsule. Of this we have no definite evidence, as the ligaments were removed in preparing the specimen. This cast of a specimen is from the Mütter Museum of the College of Physicians, and represents an impacted fracture of the femoral neck in which there was inversion of the leg. The patient was under the care of Dr. Conklin, of Ohio.

I have made these prefatory remarks to introduce the clinical history of a patient who has now good use of her limb subsequent to an intracapsular fracture, although treatment was abandoned shortly after the receipt of the injury. She has probably a short fibrous union; possibly a true bony one. In either event, however, the result is gratifying; and teaches that such cases should not be looked upon as necessarily hopeless in respect to union.

She is a German, 78 years old, and was admitted to my ward in St. Mary's Hospital, on August 30th, 1884, after falling from a street car. The resident surgeon believed there was no fracture at the hip; but on my visit I considered that the position of the limb and the patient's age pointed to intracapsular fracture of the neck of the femur. On taking hold of the leg and making rotation without violence I felt indistinct crepitation. At once desisting from further manipulation, I ordered permanent extension by weights and lateral support by sand bags to be the treatment. Within four days incontinence of urine, the development of a superficial bed-sore and the debilitated condition of the patient showed me that there was danger of the aged woman dying. I accordingly ordered the resident surgeon to discontinue the fracture dressing, so that the patient's buttocks and back could be kept clean and the bed-sore properly dressed; telling him that no union of the fracture was likely to occur, and that we must endeavor to save life by tonics, stimulants and food, and the prevention of further bed-sores. I gave a similar prognosis to to my Polyclinic pupils who saw the case. Ten days later, that is two-weeks from the time of injury, another incipient bed-sore was noticed on the buttocks. The hospital notes of this date say that I ordered change of posture to be frequently made, and that she sit up as soon as possible. Six days subsequently she was sitting up in a chair. I am unable to say whether she got out of bed previous

to this date or not. The bladder symptoms gradually improved, she soon sat up all day, and on October 4th, five weeks after admission, it is recorded that she was walking on crutches. On October 26th she was able to walk a little *without* crutches, though she did not do so much. She continued to gain in activity until her discharge, on November 2nd.

The result was so unexpected to me, for no restraint of motion at the hip was attempted after four days, that I almost mistrusted my diagnosis, and concluded that possibly the resident surgeon's original diagnosis was correct. I had made no investigation of the condition of the limb since she began sitting up. A few days before her discharge, however, I put her in bed, and with my colleague, Dr. Keen, examined her. The leg was strongly everted, as in intracapsular fracture, immediately after the injury, and she was able to invert it only so far as to make the toes nearly vertical. She could raise the leg, however, and lay it across the other or carry it outward, and, indeed, appeared to have every motion of the joint, except full inversion, though she stated it was a little stiff when walking. She had no pain. The everted leg, therefore, made the correctness of my diagnosis an established fact. Here, then, in a woman of seventy-eight years, was obtained union and a useful limb, despite the absence of treatment. In the face of such result, treatment should always be attempted, and not abandoned unless circumstances, such as arose here, demand its discontinuance. Well directed treatment will certainly be expected to make many good cures, if no treatment will occasionally give so excellent a limb.

TREATMENT OF TUMORS.

Dr. McNaughton Jones (*Med. Press and Circular*) gives the following advice in regard to the treatment of tumors:

The larger our experience of tumors of the mammary gland becomes, the more do we see the uselessness of trusting to external applications of any kind to dissipate them. Iodide of potassium, iodide of lead, iodine, the oleates of lead and mercury, discutient lotions of chloride of ammonia with camphor, combined with compression, are at times of use in the case of small nodosities, chronic induration after inflammation, and small cystic growths, but they more frequently fail, and unless growth is otherwise arrested, the use of the knife is sooner or later called for.

Lipomatous tumors, small cystic tumors, galactoceles, adenomatous nodules, may remain for years if not permanently, without growing or giving rise to any pain or even uneasiness, and all such growths cause great uneasiness in the mind of the woman, and make her apprehensive and unhappy. I am not so certain that if the rule to completely

remove any circumscribed growths from the mamme, whether painful or otherwise were generally acted on we would not be on the safer side than to temporize with any.

Take what pains we may to assure a patient of the harmlessness of any form of breast tumor, there is a natural fear of malignant disease which tends to make her mind dwell on its presence. Also, in the instance of cystic or sarcomatous growths we know sufficient of their liability to assume a malignant nature to make us, even after years of quiescence, wish they were out of the way of harm. The surgeon is perhaps more often in doubt as to the expediency of removal of the mere growth or of the entire mammary gland. His decision must depend on the homologous or heterologous character of the growth, its size, hardness, the puckering of skin, rapidity of growth, the extent of the gland involved, and the other features which make suspicious of its malignant or sarcomatous nature. Small, circumscribed and encysted tumors of a benign type may be carefully removed, but if there are any reasonable grounds for apprehension that the disease is of a malignant nature, or likely to become so, or again, that the tumor is of large size, the best course is to amputate the breast. Encysted tumors containing fluid may be incised, and the cyst cavity treated with some stimulating fluid, as solution of iodine, carbolic acid or chloride of zinc. The nature of the fluid may be determined on previously, by drawing off a small quantity with a hypodermic syringe and examining it so as to ascertain whether it is serous, hydatid or sanguineous. Hydatid tumors must be removed. *The one safe rule in all cases of malignant growth of the breast is early amputation of the entire breast.* If the axillary glands are enlarged, these should be carefully removed at the same time and the entire axilla cleared of all suspicious nodules. The association of eczematous inflammation of the nipple and malignant disease (Paget) must not be forgotten. In a well-marked case of this nature exhibited by me at the Pathological Society of London in 1881 the woman had suffered for over two years from excoriation of the nipple, and when she was admitted to the hospital there was an area of the circumference of a crown piece, including the nipple, of eczematous ulceration (eczema rubrum). Close to the axilla was a hard mass of scirrhus, which had been ulcerated, leaving a raw surface of the vivid red coloring of malignant ulceration. I removed in this case the breast, the incision being about ten inches in length, so as to include the entire area of scirrhus infiltration near the axilla. I dissected away all the glands from the apex to the floor of the axilla. The entire dissection of the axillary structures was as clean as if the part were prepared for demonstration. Yet in one year after the operation the patient returned to the hospital with a huge fungous mass protruding from the left

side of the wound. (This specimen is in the museum of the Queen's College, Cork). Only in one instance of extensive scirrhus have I operated in which there was no return of the tumor. The patient died of an attack of acute inflammation of the lungs about two years after the operation, and the breast had given her not the least uneasiness up to the time of her death. Yet it might have developed subsequently. We may decide the question of operation on these grounds:

1. The size of the tumor and the degree of infiltration of the mammary tissues; the extent to which the skin is involved, as well as the condition of the axillary glands.

2. The general health of the patient and the co-existence of malignant disease elsewhere, or of other serious constitutional disorders, as phthisis or uterine disease.

If we determine not to operate, we must palliate and relieve pain to the best of our ability by such means as compression, anodyne applications, as opium, belladonna, conium and hyoscyamus, in the form either of fomentation, ointment, or strapping, while both morphia and atropine or cocaine may be administered subcutaneously.

In conclusion, I would say in regard to any malignant or suspected malignant tumor of the breast, "Remove early, remove the entire breast, sufficient skin and all suspicious tissues and lymphatic glands.

Amputation of the breast.—Perhaps there is no operation in which the benefit of antiseptic surgery is more perfectly illustrated than in this. Union by first intention is the rule. To secure this result we should arrest hemorrhage by torsion, which if properly carried out, and care taken that the wound is not closed until all the bleeding has ceased, I find is quite efficacious, and there is little fear of any secondary hemorrhage. If ligatures are used let them be of carbolized gut. Operate with every antiseptic precaution and dress with drainage tube, and the usual antiseptic dressings. Use silver sutures or catgut to unite the margins of the wound; remove a few of these if there be any undue tension, within forty-eight hours after the operation. Dress subsequently and daily under some antiseptic spray until the wound has united. When the wound is healing cover it with a weak thymol or benzoated dressing and a thymol pad.

THE "UNCONTROLLABLE" VOMITING OF PREGNANCY.

A paper on the above subject by Dr. Grailly Hewitt, read before the Obstetrical Society of London, is summarized in the *Medical Times* (November 22). Its conclusions are based upon two series of cases in which the condition of the body and cervix were recorded, and are as follows:—

(1) That the case in which the disease is due to some other organ than the uterus are so few in number (only one in the series of 32) that they may be almost excluded from consideration. (2) That in the large majority of cases the disease presents itself during the first half of pregnancy. (3) That the evidence points to interference with the normal expansion and growth of the gravid uterus as the condition of the production of this dangerous affection, and that this is most frequently brought about by or in connection with retention of the bulk of the uterus in the bony pelvis, in 88 per cent. the uterus being anteflexed or anteverted, and in 12 per cent. in a state of retroversion, the other conditions met with being hardness, resistance, or unusual rigidity of the os and tissues of the cervix. (4) There appear to be two factors to be considered capable of interfering with the expansion of the uterus (a) incarceration with flexion or version; (b) undue hardness, and rigidity of os and cervix. These may be conjoined in a given case. It appears to be borne out by the facts recorded that the incarceration is the more important of the two factors, as a rule at least. The facts appear to point to the occurrence of embarrassment in the expansion of the uterus very early in the pregnancy, such as might be expected to be occasioned by a previously flexed state of the uterus or by a congested indurated state of the cervix, or by the two conditions combined. As the pregnancy advances, the congestion and swelling are intensified, and the resistance to expansion thus increased. It appears probable that the particular cause of the sickness observed is the compression of the nerves situated in the tissues which are especially exposed to compression, namely, those around the cervix uteri, and especially those near the internal os. Copeman's success in the treatment of severe sickness by dilating the internal os is evidence in this direction. The importance of the flexion element has been denied, one principal objection being that sickness is not always present when the uterus is flexed. But the case is the same in the non-gravid uterus; severe sickness is not seldom due to flexion of the non-gravid uterus, while flexions are observed without sickness. Corroboration of the author's views are contained in Gehrung's recent paper. As a rule, severe sickness is limited to the first half of pregnancy, in a very few cases it persists longer; in these rare cases, the cause may be rigidity of the tissues round the internal os, persisting to a late period. As regards treatment, the first indication is to secure the normal upward movement of the fundus uteri, to relieve the incarceration of the uterus, when present, if that be possible, and to prevent its occurrence by a properly arranged method of treatment. Absolute rest in the supine position if anteversion be present or on the face or side if retroversion be present, and the use of the knee-

elbow position will be required. These measures suffice in many cases. If the uterus be fixed, gentle continuous pressure must be applied internally by the fingers, or by an air-ball, and the position maintained by a suitable pessary. These measures failing, Copeman's procedure of dilating the cervix should be employed. Artificial abortion, will, it is believed, be rendered unnecessary if the less severe measures are applied early.—*Boston Med. Journal.*

NEW YORK STATE MEDICAL SOCIETY.

We give below a digest from the *N. Y. Med. Journal* of some of the papers read before the N. Y. State Medical Society on the 3rd, 4th and 5th, ult.

ACUTE PELVIC ABSCESS.—Dr. W. W. Potter, of Buffalo, read a paper with this title. The case was one of a large non-puerperal collection of foetid pus behind the uterus, of rapid formation and accompanied with marked constitutional disturbance. The aspirator was employed when fluctuation was well marked, with result of complete relief from pain, but the patient's general condition was still precarious. Various antiseptic injections having been used with little or no result, an iodoform emulsion was introduced into the abscess cavity, after the method used by Dr. Prince, of Illinois, and with the speedy occurrence of improvement. The patient made a good recovery. Before the attack came on the patient had been taking cotton-root tea in large quantities by the advice of an irregular practitioner who had diagnosed ovarian trouble; and it was a question if this had not something to do with causing the inflammation. The author referred to the frequency and importance of pelvic cellulitis, and credited Emmet with having done great service to gynecology by emphasizing the leading part played by the affection in connection with pelvic disease. As to treatment, the author advocated the radical procedure of prompt evacuation, characterizing it as "the treatment of to-day." It was only by the vagina that pus could safely escape by spontaneous opening, but there was nothing to assure us that the abscess would not break in some other direction if there was no interference with it. The necessity of antiseptic injections into the cavity was insisted upon, and they should be given by the physician himself.

Dr. Wylie, of New York, thought that the abscess must have been due either to an hæmatocele or to the access of septic material from the oviduct. He thought, too, that it was not the cellular tissue that was the seat of the collection, but the peritoneal cavity. He would prefer a trocar and canula, with subsequent dilatation, to a knife for opening such a collection. Caution should be observed in

washing out such a cavity with so strong a solution of bichloride of mercury as a 1-3,00 solution. Many pelvic abscesses, especially those of the cellular tissue, were quite as apt to point elsewhere as in the vagina, and in such, laparotomy with proper precautions, seemed to him the proper procedure, with removal of the oviducts.

Dr. Ely, of Rochester, reported a case of what might be termed "latent pelvic abscess," in a girl of sixteen years. The collection was large when attention was first directed to the abdomen. A large curved trocar was passed into the abdomen, below the umbilicus, and out through the posterior vault of the vagina, and through the canula a drainage-tube was passed. This "through-drainage" was speedily followed by recovery.

Dr. Bowditch, of Boston, related a case of pelvic abscess in a child two years of age, that had been treated like Dr. Ely's case, except that a re-accumulation of the pus led to incision and washing out of the abdominal cavity, with the most favorable result. We were still too much afraid of opening the abdomen, as, twenty years ago, we were too much afraid of opening the chest.

PEROXIDE OF HYDROGEN.—Dr. S. S. Wallian, of Bloomingdale, read a paper on this subject. It was said that it might take the place of ozone for many purposes, as a germicide, etc., while it was perfectly harmless in the form in which it was used in medicine. It acted by parting with a portion of its oxygen, which, no doubt endowed with the peculiar activity incident to the nascent state, combined directly with septic substances, and thus put a stop to the putrefactive process. The author then gave a summary of its therapeutical applications, with special reference to its use in the treatment of diphtheria. Cases of carbuncle, sloughing ulcer, and septic infection (one of each) were then alluded to as having occurred in the author's practice and having been treated with the peroxide with brilliant results.

A CASE OF CANCER OF THE LIVER, characterized by a series of low temperatures, was then related in a paper by Dr. W. S. Ely, of Rochester. An uncommonly full record of temperature observations had been kept. A great number of them showed a subnormal temperature—the lowest being 91° F. There were no signs of collapse at any time, and there was no correspondence between the state of the temperature and that of the pulse, but the patient felt cold to the touch. There could be no error about the observations, as they had all been made by an experienced nurse, with a Hick's thermometer accompanied by a certificate issued from the Yale Observatory. The inferences were, that subnormal temperatures were not always so dangerous as was generally supposed, and that thermometers ought to be graduated lower than was commonly the case.

TUBAL PREGNANCY.—Dr. Squire, of Elmira, read an account of a case of tubal pregnancy in which the sac ruptured, peritonitis followed, and the fetus was subsequently felt in Douglas's pouch, together with a large quantity of foetid blood. The collection then burst into the rectum, with marked relief for a time, but subsequently blood-poisoning showed itself, and laparotomy was performed. The effusion was found walled in above by a false diaphragm of lymph exudate, and the operation was abandoned. Nevertheless, the patient at once began to improve, but, some months later, she began to sink again, and died nine months after the rupture of the sac. At the autopsy, an abscess containing about twelve ounces of pus was found in the right broad ligament.

DOES QUININE ABORT PNEUMONIA?—Dr. Holt, of New York, read a paper with this title.

Dr. Bell, of Brooklyn, spoke of the malarial origin of cases of pneumonia that he had treated, particularly among children, and in the swamps of the Chickahominy.

Dr. Loomis, of New York, thought the question really was, whether the passive hyperæmia of malarial disease was identical with that of the first stage of pneumonia. Passive hyperæmia, especially in children, gave rise to physical signs that might easily lead to the case being taken for pneumonia; but he did not think such cases of engorgement would go on to the development of pneumonia, except under the influence of something else than malaria. It was impossible to stop the course of a lobar pneumonia—a disease which, he thought, was truly infectious. Was the pneumonia of to-day different from that of fifteen or twenty years ago? In his opinion, there had been no more change in the character of pneumonia than in that of a number of other diseases, such as diphtheria and cerebro-spinal fever.

SENILE HYPERTROPHY OF THE PROSTATE was the title of a paper read by Dr. Post. The paper dealt with the subject in a systematic manner, so as scarcely to admit of a synopsis. The author showed a special syringe, of his own device, for attaching to a catheter in the procedure of washing out the bladder. It was so constructed as to admit of repair readily without its being sent to an instrument-maker, and of being attached to any ordinary-sized catheter. Stress was laid on the advantage of using large catheters in cases of prostatic disease, for the reasons that are commonly given. In the use of very flexible rubber catheters, it was sometimes useful to stiffen the distal part of the instrument by coating it with collodion. In very aggravated cases of cystitis, he had found much relief produced by applying the actual cautery to the pubic region. He was inclined to favor a resort to crushing or other operative procedures in some cases of very difficult catheterization, but the opinions of surgeons with regard to these measures were diverse.

CHOLERA AND QUARANTINE.—Dr. Van der Poel gave an extemporized *résumé* of his paper on this subject. His remarks had special reference to the question of the probable efficacy of quarantine in preventing the importation of cholera. The speaker gave an interesting description of the measures that were taken on the Red Sea route of travel, under an authority of an international sanitary board, to prevent the transportation of cholera from Calcutta and Bombay: they were almost always efficient, but occasionally the luke-warmness of the British officials thwarted them, a notable instance of which was seen in the landing of a steamer's load of steerage passengers on the western shore of the Red Sea, in order to elude observation, and the consequent spread of the disease to Egypt and thence to France. As to quarantine in the old sense of the term—absolute detention and non-intercourse—that was not what sanitarians now meant when they spoke of quarantine, but the whole system of guarding against the shipment of diseased persons, clothing, etc., when the disease broke out, so as to prevent its extension over a country. If these measures were carefully carried out, there was a great probability of our being able to stamp out the disease in case it made its appearance; but they should include detention and observation for ten days at the ports of New York, Boston, Philadelphia, Baltimore, and New Orleans. The co-operation of the Canadians could probably be counted upon, for they did not share the English view as to the uselessness of quarantine.

FORK FOR FRACTURE OF THE PATELLA.

Dr. L. A. Stimson showed before the N. Y. Surgical Society, a fork to be used in the treatment of fracture of the patella. He had expected to show a patient upon whom he had used it with success, but the man had failed to come.

In using Malgaigne's hooks he had found it difficult to insert the hooks deeply enough to adjust the screw that connects them, and he had devised this fork as a substitute. The fork is of iron, two-pronged, the prongs bent in the flat at an angle of forty-five degrees at their junction with the shaft. The prongs are one inch long and three-quarters of an inch apart; the shaft is about three inches long. There is a small ring at the base of the prongs for the attachment of an india-rubber cord, and another at the end of the shaft for the attachment of a bandage encircling the thigh.

The instrument is used by inserting the prongs through the skin above the patella and pressing them down until they rest against the upper border of the upper fragment; the shaft lies along the median line of the front of the thigh, and is prevented from tilting or moving to either side by a roller bandage wrapped around it and the thigh. Trac-

tion downward is made by a piece of India-rubber tubing, one end of which is attached to the ring at the base of the prongs and the other made fast to the front of the skin by adhesive plaster. The introduction of the prongs can be made easily and painlessly by chilling the skin with ice and making two punctures with a knife.

In the case he had treated with this fork the fracture was transverse and the separation about an inch. The separation was readily overcome by the traction. The patient made no complaint during the five weeks the instrument was in place. The patient was kept in bed, with the limb suspen-



ded in a wire gutter, and the punctures kept dusted with iodoform; there was no inflammatory reaction about them, and only a slight discharge. The lower fragment was kept gently pressed upward by an oblique turn of a roller bandage. On the removal of the fork, five weeks after the occurrence of the fracture, the fragments were closely and firmly united, without independent mobility. As a precaution, a plaster bandage was then applied, and not removed until the end of the ninth week. The knee could then be flexed nearly to a right angle, and there was still neither independent mobility nor separation of the fragments.

ESSENTIAL EPILEPSY.—The *Phila. Med. Times* gives the following clinic by Prof. Pepper:

This little girl has been before you on one or two occasions. Let me recall to your minds the more important features in her history. She is ten years of age, born of healthy parents, with no inherited morbid tendency, and lives in a healthy

neighborhood. Up to the age of five years she was apparently healthy, but at this time it was noticed that she was "nervous" when her attention was strongly fixed. There is no history of severe sickness or other cause to account for this. Shortly after this it was noticed that the child began to have falling-spells, and these would sometimes recur as often as two or three times a day, and at no time did she go a week without an attack. In these seizures she would fall to the floor if there was no one at hand to support her, and she evidently lost consciousness for the moment, for she would assert that some one had thrown her down. There was no general convulsion, but for a few minutes there would be trembling of the hands. She did not froth at the mouth or roll the eyes, but after the attack had passed she became very red in the face.

She was brought to the hospital four months ago. At that time she was having the spells very frequently, and the mother could not trust her out of her sight. Her memory was also much impaired.

The story of this case is one of apparently essential epilepsy. No peripheral cause can be found for these attacks. The child has no heart-disease; there is no history of an injury or of a sudden shock of any kind, but gradually, without apparent cause, she at the age of five years began to have these attacks, which continued to increase in frequency until four months ago.

At that time, learning that the girl had been under the care of the family physician for some time, I concluded that the bromides had been thoroughly tried. The child was exceedingly feeble; she would drop down on the slightest exertion, and many of the falls were undoubtedly the result of muscular prostration and debility. There was also to a remarkable extent a want of mental activity. The child was listless, and her memory was rapidly failing. Concluding then that the bromides had been used, I considered it useless to push them. I thought it better to direct attention to hygiene, diet, the administration of tonic remedies, and trust to the development of the system, rather than attempt by specific remedies to coerce the manifestations of the disease.

I ordered a properly-regulated diet and the use of a simple solution of the phosphates of soda, lime and iron in an excess of dilute phosphoric acid. The child had no other treatment.

The mother reports that there has been decided improvement. The attacks do not recur so often, a week frequently intervening between the attacks. The disease is, however, far from being checked, but we are encouraged to persist in the plan of treatment adopted. In the meantime the child will be kept from school, the mother teaching her at home.

AN OLD FORM WHICH MIGHT WELL BE REVIVED, —To the kindness of Prof. Osler we owe the following copy of an indenture which was in use in the early part of the century in England, and which seems of sufficient interest to warrant publication. We commend it to the State Medical Society (*Med. Times*).

"*This Indenture Witnesseth*, That Edward O—, of the town of Falmouth, in the county of Cornwall, by and with the consent of his Father, doth put himself Apprentice to James X., of said town of Falmouth, Surgeon, to learn his Art and with him, after the manner of an Apprentice, to serve from the 2nd day of March, eighteen hundred and Eleven, the full End and term of five years from thence next following, to be fully complete and ended.

"*During* which term the said Apprentice his Master faithfully will serve, his secrets keep, his lawful commands everywhere gladly do. He shall do no damage to his said Master, nor see to be done of others, but to his Power shall let or forthwith give warning to his Master of the same. He shall not waste the Goods of his said Master, nor lend them unlawfully to any; he shall not commit fornication or contract Matrimony within the said term. He shall not play at Cards or Dice-Tables, or any other unlawful Games whereby his said Master may have any loss, with his own goods or others during the said term, without the license of his said Master. He shall neither buy nor sell; he shall not haunt Taverns nor Play-houses, nor absent himself from his said Master's Service day or night unlawfully, but in all things as a faithful apprentice he shall behave himself towards his said Master and all during the said term.

"And the said James X., for and in consideration of the sum of forty pounds lawful money of Great Britain, one moiety of which to him in hand paid, the other moiety when half the term is complete, the said Apprentice in the Art of Surgery and Physic which he useth by the best means that he can shall teach and instruct or cause to be taught and instructed, Finding unto the said Apprentice sufficient meat, drink, lodging, and all other necessities during the said term.

"And for the true performance of all and every the said Covenants and Agreements, either of the said Parties bindeth himself to the Other by these Presents.

"In witness whereof, the parties above named to these Indentures interchangeably have put their hands and seals this 22^d day of March, and in the fifty-first year of our Sovereign Lord George III., by the Grace of God of the United Kingdom of Great Britain and Ireland King, Defender of the Faith, and in the Year of our Lord one thousand eight hundred and eleven.

"Signed, sealed, and delivered in the presence of
"I. GRIFFIN."

CHRONIC ARTICULAR DISEASE.—In the *Lancet*, Nov. 1884, p. 763, is published a lecture by Mr. Barwell, concerning the management of two principal forms of chronic articular disease; (1) that arising in the bone, and (2) that commencing in the synovial membrane. The author takes a case, in which he supposes that a certain portion of bone is enlarged, painful, and particularly sensitive to pressure; that the pain augments at night, and the limb starts violently just as the patient is falling to sleep, and the skin over the tender point of bone is red. These symptoms show that suppuration is imminent or has already commenced. This is the time for the surgeon to step in, and he should choose a point whence he could reach the bone without opening the synovial cavity; and here, pushing aside a little flap of soft parts, together with the easily detached periosteum, he may with a small trephine-head make an opening in the bone. While this is being done, he must observe what sort of fluid flows. If it be not pus, he must explore with a needle until pus is reached, or until it is certain no pus has formed. Pus, when present, should be detected and eliminated; but the treatment answers as well if pus have not already formed. After having established an opening, it should be kept open by means of a drainage-tube, so as to allow the cavity to heal with granulation from the bottom.

The author next goes on to the treatment of the sluggish form of synovial disease met with in strumous subjects, where there is a persistent tendency to the growth of flabby granulations which may ultimately undergo suppuration.

In these cases, the greatest value will be found in applying pressure to the affected part. This may be done by means of ordinary strapping, or by strapping one of the medicated plasters over the joint. The strapping should be often changed so as to make the pressure equable as well as persistent, and in many cases this is best attained by using a bandage of elastic webbing. If the swelling be large and soft, mere pressure is rarely sufficient; but the granulations must also be stimulated and this is effected by injecting among them a solution of some slight irritant. The best fluid to use is tincture of iodine, beginning with half a drachm to the ounce of distilled water, and increasing up to two drachms are generally sufficient, and this may be repeated once or twice a week. The limb must be placed in the most advantageous position, as a certain amount of stiffness is bound to follow; and great care must be taken to prevent as much as possible the limb from becoming fixed in any awkward position.—*The London Medical Record*.

A CENTRAL TUMOR CAUSES JACKSONIAN EPILEPSY.—Dr. William Osler, of the University of Pennsylvania, records in the January issue of *The American Journal of the Medical Sciences* the history of an instructive case of Jacksonian epilepsy,

the main points of difference between which and true epilepsy are the slow onset, local in character, beginning in (or in mild attacks confined to) one limb or a single group of muscles; the gradual extension until the side is involved, or in severe attacks the entire body; loss of consciousness late, not early and sudden as in true epilepsy; and, lastly, the muscular contractions are clonic.

His case lasted over fourteen years, the convulsions beginning in the left hand, at first monobrachial, then extending to the leg, afterwards becoming unilateral, and finally general; at first without loss of consciousness. For the first nine years of the illness there were remarkable intermissions, lasting for six or seven months, once for an entire year. Six years after the onset, the leg got weak and stiff. For four years, the tenth, eleventh, twelfth, and thirteenth years of the illness, the seizures were frequent. During this period there were six weeks of unconsciousness, in which spasms were very frequent, from fifty to eighty in the day. Ten months prior to the final attacks there was freedom from convulsions. The intellectual faculties were unimpaired.

The case was unusual in the limitation of the lesion to the ascending frontal convolution and to its fasciculus of white matter, scarcely involving the grey substance, which is commonly affected in cortical epilepsy. The accurate localization and the remarkable absence of tissue-changes in the immediate vicinity give the case the nature of an exact physiological experiment. With this limited lesion of the motor area there was permanent paralysis with contracture of one extremity and epileptiform convulsions. Another feature of interest in the case is the light it throws on the situation of the leg-centre. The fibrous mass was situated entirely within the anterior part of the paracentral lobule, limited in extent, confined chiefly to the medullary fibres of the superior frontal fasciculus, and only touched the grey matter in places. A point to be referred to is the absence of the paralysis of the leg for the first six years; for if the convulsions and monoplegia were caused by the same lesion, how explain the late onset of the latter? From the fibroid state of the tumor it might reasonably be inferred that it was originally larger and had shrunk; but the absence of puckering on the surface, and the way in which the margins merged with the contiguous parts, make it probable that the growth was always small, so small in fact that at one period of its development it may have caused sufficient irritation to induce the convulsions, and yet at the same time not involve the special fasciculi of white fibres to the extent of producing weakness of the leg, or monoplegia.

THE EXTERNAL USE OF CHLOROFORM IN LABOR.—The *Chicago Medical Journal and Examiner* calls attention to a peculiar method of using

chloroform in labor, which originated, it is said, with Dr. A. Svanberg, of Sweden. This doctor claims to have found that, in severe cases of labor where rigidity of the os has caused an obstacle to delivery, the external use of chloroform is very advantageous. His method consists in applying a piece of flannel soaked in a mixture of chloroform and sweet-oil (one to one or two to one) to the abdomen between the symphysis and navel. Then by light strokes over the cloth he makes sure that it is close to the skin. In severe cases (after five minutes) he pours on more of the mixture. After from five to twenty minutes Dr. Svanberg always finds that the rigidity is so much lessened that any desired manipulations, such as turning, may be performed. Five cases are reported, illustrating the efficacy of this measure.

In December, 1877, he, with three other doctors, was called to a labor, in a primipara, rachitic, with small pelvis, transverse presentation, with arm protruding. The uterus was firmly contracted around the fœtus, and it was impossible to pass the hand into it, with the view of turning. She was completely anæsthetized, and continued thus for more than an hour without result. A warm bath was given, then again chloroform, but all in vain. At last he proposed to try chloroform externally, and in about fifteen minutes he could proceed with the turning.

This practice of applying chloroform externally in order to relax the parts and permit the introduction of the hand or instruments, is especially recommended to country doctors who have no assistant to give the anæsthetic by inhalation. It is not believed that it will succeed in very severe cases. It is probable that the patient practically gets a good deal of chloroform internally by this method.—*Med. Record.*

INTRA-UTERINE MEDICATION.—Dr. Lombe Atthill read a paper on this subject before the last meeting of the British Medical Association, and gave the following conclusions :

1. Carbolic acid in the proportion of one part of spirit to two of the acid, is the safest and most generally useful of all the agents employed.

2. Carbolic acid should always be applied by means of a probe, round the point of which a layer of cotton is rolled, the cotton being carried up to the fundus at least twice on each occasion that the applications are made, which should be on every third or fourth day, till marked improvement takes place.

3. Carbolic acid should never be injected into the uterus, except when combined with iodine, in the forms known as iodized phenol.

4. In many cases, iodized phenol may with advantage be applied by means of a probe.

5. In cases in which metrorrhagia or profuse menstruation occurs, depending on an unhealthy

condition of the intra-uterine mucous membrane, the cavity being dilated and the uterus enlarged, from half a drachm to a drachm of iodized phenol may be injected with great advantage.

6. In cases in which epithelioma attacks the mucous membrane of the cavity, the injection of iodized phenol promises better results than any other treatment.

7. The success likely to follow the injection of iodized phenol renders the dilatation of the uterus, the use of the curette, and the subsequent application of fuming nitric acid, less frequently necessary than has been the case hitherto.

8. The injection of iodized phenol requires to be carried out with so much care, that it should never be injected except by means of a syringe which will not contain more than one drachm.

9. The use of the fuming nitric acid should be limited, as a rule, to those cases in which dilatation has been practised, and it should always be applied through a tube, inserted into the cervix uteri for the purpose of protecting the sides of that canal from the action of the acid.

10. The pain produced by the application of any medical agent to the intra-uterine cavity, does not bear any relation to the activity of that agent, but is due to one of two causes—either to hyperæsthesia, or to narrowness of the cervical canal, especially of the os internum.

MEDICAL FEES IN THE ARGENTINE REPUBLIC.—A correspondent in the *British Medical Journal* (Jan. 10, 1884) gives the following as the scale of fees in the Argentine Republic:

"The ordinary charge for a consultation at a medical man's house is said to be two dollars (about 8s.); for a visit, four dollars, say 16s.; for attendance at confinement when all goes well, about £20; but when any special care or operation is required, these fees amount up to hundreds of pounds. Accounts for medical attendance are sent in and paid without remark, which would make the hair of a paterfamilias in the 'old country' stand on end. My friend mentions the following fees as having been lately obtained by doctors who, though of good standing, are not looked on as 'stars': For extraction of ovarian tumor, £1200; amputation of arm, principal, £600; amputation of arm, two assistants, each, £400; delivery with operation, £400; attendance during typhoid fever, £200; visit by a physician for dropsy, £50; consultation fees, £20 and upwards. Much depends, of course, on the position of the patient, but there are sufficient wealthy people to make up for any small fees or gratuitous work which may have to be done among the poorer classes.

"The statements given above are confirmed by another correspondent, who states that a friend of his paid £100 for attendance at the confinement of his wife, and adds that the charges by dentists

are on a like magnificent scale, as much as £5 or £6 being paid for stopping a tooth. There, however, appears to be one important condition: before a doctor is allowed to practice in the Argentine Republic, he must pass an examination, and be licensed by the Government Medical Board; and before he can do this he must, of course, be master of the Spanish language. The population of the country is so cosmopolitan, that the more modern languages he speaks, the better will be his chances for success."

TREATMENT OF CHOLERA—In view of the expected visit of the cholera to this country during the coming year, any contribution to medical literature, bearing upon the treatment of this disease, should receive careful and earnest consideration on a part of the medical profession. From the researches of Dr. Koch, it is now known that acids are most useful to kill the cholera microbe, and have been successfully employed by the profession in Europe.

Dr. Chas. Gatchell, of Chicago, in his "Treatment of Cholera," says: As it is known that the cholera microbe does not flourish in acid solutions, it would be well to slightly acidulate the drinking water. This may be done by adding to each glass of water half a teaspoonful of Horsford's Acid Phosphate. This will not only render the water of an acid reaction, but also render boiled water more agreeable to the taste. It may be sweetened if desired. The Acid Phosphate, taken as recommended, will also tend to invigorate the system and correct debility, thus giving increased power of resistance to disease. It is the acid of the system, a product of the gastric functions, and hence, will not create that disturbance likely to follow the use of mineral acids."

The following case is reported from Bangkok, Siam, and may be relied on as authentic: About three months ago a native was attacked with cholera. An American Missionary attended him, and administered all medicines he could, but at last the man was so far gone that they gave up all hopes of recovery, and would do no more. Relatives of the patient begging the doctor not to give him up as lost, the doctor thought of Horsford's Acid Phosphate. After the second dose the patient commenced to revive, and in six hours after, he was pronounced out of danger.

DIFFICULTY OF DIAGNOSIS BETWEEN PLEURISY AND PNEUMONIA IN CHILDREN.—Dr. J. Lewis Smith (*N. Y. Path. Society*) related the following case, and requested Dr. Northrup to give an account of the post mortem: An infant, aged eleven months, had for two months been ailing with whooping-cough. Ten days preceding the 24th of the month the bronchitis accompanying the whooping cough became aggravated. Then, in addition

to capillary bronchitis, there was an almost flat percussion sound over the right side of the chest except anteriorly, where the dulness was less marked. He supposed, therefore, that the child had pleurisy with effusion. The attending physician afterward aspirated the chest and failed to withdraw any fluid. Dr. Smith was obliged, then, to accept the probable diagnosis of pneumonia with thick fibrinous exudation over the lung. The difficulty often existed of distinguishing between pneumonia and pleurisy with effusion in children under fifteen months of age. In the present instance, as in many cases, no enlargement of the affected side could be noticed; not even bulging in the intercostal spaces.

Dr. Northrup then gave the results of the autopsy. The lungs were much more than usually compressed, and were slightly adherent anteriorly. In the pleural cavity was a pint of greenish-yellow fluid containing pus. The lung was so carnified that it scarcely rose to the surface of the water. Dr. Northrup said there were records of as many as from seventy-five to one hundred post-mortem examinations on the books of the asylum in which a mistake in diagnosis had been made between pleurisy and pneumonia in children.—*N. Y. Med. Journal*.

PERMANENT CORROSIVE SUBLIMATE SOLUTION.—Mr. Joseph Bulfin, in a note to the *Medical Times and Gazette* of November 1st, says: I have for some time been engaged in experiments and trials of various antiseptics, carbolic acid, eucalyptus, thymol, and iodoform, and since reading your article on Sir Joseph Lister's address, have made some on the following, which I think would be worth a trial. The modification which I would venture to propose is as follows: Corrosive sublimate, 3ij; white of egg, 3vj; Barff's boroglyceride, 3xii; distilled water, 3cxxv. M. The strength of the corrosive sublimate in this solution will be nearly 1 to 500. As it would be almost impossible to add the precise quantity of albumen to render the bichloride of mercury unirritating and safe, it is desirable to add an excess of albumen; but an excess of albumen on the other hand, if allowed to decompose, would be objectionable in the extreme, to obviate which I suggest the introduction of boroglyceride which, without in any way interfering with the action of albumen, whether used from blood serum or white of egg, will guard against the products of decomposition from the use of an excessive amount. The proportion of mercury used in the compound may be increased or diminished as occasion may require, and all are non-volatile. Charpie, cotton-wool, or oakum saturated in such a solution would, in my opinion, form one of the best antiseptic dressings that I have yet seen, and for the chief part of this I am indebted to Sir Joseph Lister, my only contribution being the in-

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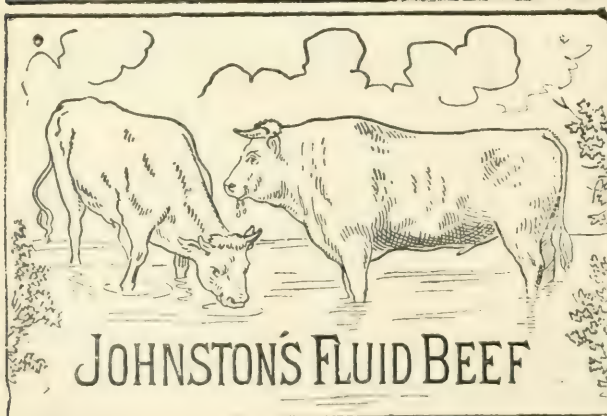
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roduction of boroglyceride.—*Med. Times and Gazette*, November 1, 1884.

TENOTOMY OF THE LEVATOR PROSTATÆ IN ENLARGEMENT. — Dr. Wyman in the *Medical Age* gives the following as his conclusions in regard to the treatment of enlarged prostate :—

1. The tendon of the levator ani muscle unites with the central tendon of the perineum, and invests the prostate gland in such a manner that when the prostate is enlarged, force is brought to bear upon it during efforts to evacuate the bladder, which rotates the prostate upon the urethra and shuts off the flow of urine.

2. A section of the perineum and its deep fascia and central tendon, will remove the force expended by the levator ani muscle in producing version of the prostate, and permit the muscles of the abdomen and bladder to evacuate the urine. Such a section implies tenotomy of what some anatomists call the *levator prostatæ* muscle.

3. An operation of this character involves a breaking up of the veins and lymph spaces on the rectal and lateral aspect of the prostate, and, if the wound is made to granulate from the bottom, atrophy of the prostate will follow, so that by the time the tendon of the levator prostatæ has reunited, no further difficulty in micturition will be likely to ensue.

CHLORAL IN ALBUMINURIA. — Burduzzi (London *Med. Record*) in 1878, noticed the good effect of chloral in albuminuria, recently confirmed by Dr. Wilson in the *Brit. Med. Jour.* His case in 1878 was that of a lady, suffering from insomnia in the last months of pregnancy, with dyspnoea, from general oedema of the legs and hands, and with highly albuminous urine, in which he ordered 2 grammes of chloral to be taken in two doses every evening. This treatment was continued for about twenty days with very good effects; sound restorative sleep was not only obtained, but the oedema disappeared, and the quantity of albumen in the urine was notably diminished. Labor followed in due course, and was in every respect normal, and the puerperium was free from any complication. Since then Burduzzi has always prescribed chloral in the last month of pregnancy, when there is much oedema, and the urine is scanty and albuminous, as a prophylactic against eclampsia. In a man, 45 years of age, affected by simple nephritis, chloral in doses of 3 grammes a day procured great relief in a short time, and the albumen almost entirely disappeared from the urine. In the so-called physiological albuminuria, chloral is also useful, as the author shows by the case of a man in whose urine albumen was almost constantly present. Burduzzi points out the need of more exact studies of the action of chloral on the renal tissue.—*Four. Am. Med. Association.*

SALICYLIC ACID A CURE FOR TIC DOULEUREUX. — We frequently meet in our practice cases of tic dououreux, that often so exceedingly painful neuralgia of the fifth nerve, where an operation seems to promise the only radical cure. If we hear of a remedy which is said to have the same effect as the surgical interference, we become doubtful; but if no less reliable authority than Prof. Nussbaum assures of the fact, our hope increases. Recently a number of such cases had been sent to N. for the purpose of having the operation performed, and, after a number of carefully-instituted experiments, this great surgeon recommends a trial with salicylic acid before proceeding to stretching or to resection of the nerve. In all the recently-sent cases he first tried this remedy, and he found it in every one a radical cure; not only a palliative effect, but really an utter disappearance of the painful disease, was the result in every case. Especially in cases of rheumatic nature, N. is positive of having discovered in salicylic acid a specific for tic dououreux. He administered the drug in the following manner: R.—Acidi salicylici, grs. $3\frac{1}{3}$; sodii salicylatis, gr. 32; M. ft. pulv. Within 24 hours the patient takes from four to six of such powders.—*Med. and Surg. Reporter.*

A PRACTICAL POINT IN THE TREATMENT OF PLEURAL EFFUSIONS.—Dr. Broadbent (*Lancet*), in a clinical lecture, says that when he hears distinct bronchial breathing generally over the chest in cases of pleural effusion, he feels sure that a consolidated lung is immersed in the fluid, and he consequently does not tap unless the symptoms are so urgent as to demand interference. A solidified lung can not, of course, expand, as does one which is simply collapsed, or even compressed, unless it is bound down by adhesions; and experience has shown him that, on the resolution of the pneumonia, the fluid is usually rapidly absorbed.

He seems to hold the sound views that, with grave symptoms, a pleural effusion should be withdrawn, whatever the complication; that the course of moderate effusion may often be shortened by tapping; but that, if the lung be consolidated—one evidence of which is the persistence of bronchial respiration over the whole, or a large part, of the chest—it is better to wait, if the condition of the patient warrants such a course.—*Boston Med. and Surg. Journal.*

CHLOROFORM IN LABOR.—The subject of the use of chloroform during labor continues to give rise to diverse views on the part of obstetricians, though the great majority are on the side of its employment with certain limitations. One of the limitations is the prohibition of full anaesthesia, unless it be at the moment of delivery. Up to that time it is properly employed in small quantities merely to alleviate pain without producing un-

consciousness. We have no doubt of the entire safety of this plan. Nor do we doubt that it is preferable to ether for this purpose. There appears to be no danger from chloroform, at least when used in this mode, during the throes of labor. On the contrary, the condition of labor appears to exert a remarkable protective influence against chloroform accidents. In a recent discussion in the St. Louis Obstetrical Society reported in the *Courier of Medicine*, these views were sustained by the members. The following remarks by Dr. Papin on that occasion may prove interesting to our readers :

"I have used anæsthetics in labour very extensively. With Dr. Engleman, I play with chloroform in the first stage of labor ; I become a little more earnest in the second stage ; and when the child's head begins to come out, I give a full dose and produce anæsthesia."—*Pacific M. and S. Jour.*

TREATMENT OF EPILEPSY.—The *Fort Wayne Medical Journal* gives the following formulæ in epilepsy :

R Ammonia bromide.....
Elix. valerianate ammonia. aa $\frac{3}{4}$ ij,
Fl. ext. stramonium..... $\frac{3}{4}$ ij,
Glycerine..... $\frac{3}{4}$ ij,
Syrup auranti cort. $\frac{3}{4}$ iv,
Aqua dest..... $\frac{3}{4}$ v. M.

Sig.—Tablespoonful before meals. In addition to this take from grs. xxx to grs. lx of potassium bromide at bed time. Preface this treatment with an anthelmintic combined with an active cathartic and see that the bowels are subsequently kept in a soluble condition. The writer adds the prescription of a former colleague, which he endorses, not only in epilepsy, but many other diseases of the nervous system. He asserts that it will quiet the most excited lunatic :

R Bromide of sodium..... $\frac{3}{4}$ j,
Bromide of zinc..... grs. xxx ij,
Glycerine..... $\frac{3}{4}$ j,
Aqua cinnamomi..... $\frac{3}{4}$ vij. M.

Sig.—A tablespoonful three times a day in half a wineglass of water.

PHOSPHATE OF SODA IN HEPATIC COLIC. — Dr. Briston in the *Medical News*, says :—Apropos of the recent discussion in the New York Surgical Society, as published in your issue of January 31st, you are at liberty to publish the following notes of a case occurring in the rural districts :

Mrs. J., aged 28, was seen on the 22nd of October, 1884. Found her suffering intensely, the pain being referred to the region of the gall-bladder. The patient herself was firmly of opinion that she was suffering from gall-stone, and said her sister had suffered in the same way, discharging the stones a few days after the attack. This patient

further said that she had suffered with similar attacks at intervals for ten years. On the 23d of October, having relieved the suffering of the day before by morphia hypodermically, I put her upon drachm doses of the phosphate of soda three times a day. To quote her own expression, "the region of the liver felt as if it were being ground up." On the 25th, two days after, over one hundred gall-stones, varying in size from a duckshot to a large pea, were discharged per rectum. The present health of the woman is excellent, and she has had no further trouble. The phosphate of soda was continued for several weeks, but has been dispensed with now for two months. What one of the laboratory staff of the profession will give us, the *rationale* of the action of this remedy in this class of cases, and also in catarrhal jaundice, for which it sometimes seems to act as a specific ?

DRESSINGS FOR ULCERS OF THE LEG.—B. F. Curtis, M.D., (*N. Y. Med. Journal*) states that in the out-patient department of the Chamber's Street Hospital, they have had good results from the treatment of ulcers of the leg with Lister's boric-acid dressing, applied with a crinoline bandage.

The leg and foot are thoroughly washed with a one-to-forty carbolic acid or one-to-one-thousand corrosive sublimate solution, and the ulcer itself is washed with a saturated solution of boric acid. Over the ulcer is put a thin gutta-percha tissue, which has been soaking in the boric acid solution, large enough to extend about one-fourth of an inch beyond its edges on all sides. The leg is wiped dry. Sufficient borated or salicylated cotton to take up the discharge is laid over the ulcer, and the rest of the leg from ankle to knee is wrapped with a half inch layer of cotton batting. An ordinary bandage is applied to the foot and from the ankle to the knee is applied a crinoline bandage which has been squeezed quite dry after soaking for five minutes in water. Care must be taken to have the cotton project beyond the upper and lower edges, as they may chafe the skin when dry and stiff. The crinoline will dry in half an hour ; but if time is important an ordinary bandage may be applied over the crinoline and the patient be dismissed at once.

PLASTER OF PARIS TREATMENT OF FRACTURES.—Mr. Christopher Heath in *British Med. Journal*, endeavors to induce surgeons to have more faith in the early treatment of fractures by plaster of Paris than appears as yet at all general, and thus to save the patients and themselves an infinity of trouble. In his paper he quotes from "Aphorisms" of the late Dr. Cowling of Louisville, the following, which he regards as full of common sense :

"Carved and manufactured splints generally fit nobody, and are to be rejected, as not only expen-

sive, but damaging" "The application of the roller-bandage immediately to the skin, whether as a protective or to prevent muscular spasm, has resulted in such disaster, that it is one of the curiosities of surgery how it could be repeated at this day. When cotton is placed over such a bandage, it forms an absurdity scarcely credible in a man of common sense." "Continued extension, and counter-extension, are, as a rule, not necessary to prevent shortening in fractures. This is best done by removing the causes which lead to muscular spasm; 1st, by as early and complete reposition of the fragments as possible; 2d, by the smooth application of cotton-batting to the limb; 3d, by the equal pressure of a bandage extending from the distal end of the limb to a point beyond the joint above the fracture; 4th, by the accurate fitting of the splints or plastic material for support; 5th, by as little interference afterward as possible."—*Med. Record*.

CROTON CHLORAL IN WHOOPING COUGH.—Dr. W. C. Webb, of Bryantsville, Ky., (*Am. Practitioner*) says that he has employed croton chloral in whooping cough with more benefit than he found from almost any other remedy. This drug does not derange the digestive organs, nor effect the vital nervous centres. Patients frequently fall asleep on their chairs after using it. On taking this remedy the patient must be watched lest toxic symptoms be manifested. A child from one to two years old may take 1 grain of the preparation every four hours. One ten years old, may take 2 grains as often. After the first week the dose should be lessened and given at longer intervals. Should there be much gastric irritability, or should the paroxysm be very severe, a few whiffs of chloroform may be given in advance of the croton chloral. This may be repeated only three or four times.

The following formulæ are given for its administration: R. Croton chloral, ʒj; tinct. cardamon comp.; glycerine aa ʒ ij. Sig.—One half teaspoonful every four hours for a child two years old and under; or, R. Croton chloral, ʒj; tinct. belladonna, 5 ij; tinct. cardamon comp., ʒ ij; glycerine, ʒ ij. M. Sig.—One-half teaspoonful.

CAUSTICS IN ENLARGED TONSILS.—Among various caustics for local use in causing shrinkage of tonsillar hypertrophies, Dr. Chisholm (*Virginia Medical Monthly*) has found the chloride of zinc the most available and the least annoying to the patient. He employs it in the following manner: A wire the size of a fine knitting needle, is roughened for a half inch from one end so that it may hold a fibre of absorbent cotton twisted upon it. Dip this into a saturated solution of chloride of zinc and thrust it to the very bottom of the crypt, and keep it there for several seconds. When withdrawn the whitened orifice marks the cauterization. By re-

newing the cotton for each follicle several may be thoroughly cauterized at the same sitting without causing any annoying irritation to the throat. A very few applications will cause the gland to shrink, as will be seen one week after the destructive cauterization has been made to the interior of the follicles.—*Medical Record*.

SALICYLATE OF SODA IN RHEUMATISM.—Prof. Clarke treated eleven cases of acute rheumatism—all that occurred in his ward at Bellevue—with this drug. In nine of the cases there was early improvement following the use of the medicine. In two cases the amelioration was more gradual. The influence of the medicine in "lowering the fever heat and diminishing the excited pulse were as marked as its power to relieve pain."

The formula used in all the cases is as follows:

R Acid salicylic..... ʒ ij,
Soda bicarbonat. ʒ ij,
Glycerine..... ʒ ss.
Aq..... ad ʒ viii. M.

Sig.—Tablespoonful every two hours the first day, and afterward the same dose, six times a day.

No unpleasant effect of any kind was noticed after the administration of the medicine.—*Medical Record*.

FISSURE OF THE ANUS.—Dr. Kelsey, (*New York Clin. Society*) stated that for the past two years he had not been obliged to stretch the sphincter for fissure of the anus, but had used instead a weak solution of nitrate of silver—never of more than five or ten grains to the ounce. In a recent case the patient was cured by a single application of a ten-grain solution, and in another and very severe and obstinate case a cure was effected in three weeks by this method.

Dr. Abbe has cured cases by the application of the solid stick. He thought the principle was simply to supply a coating of coagulated albumen.—*N. Y. Med. Journal*.

PUERPERAL PERITONITIS.—Dr. Garrigues, *New York Med. Journal*, speaking of the treatment of puerperal peritonitis says: At the beginning of the disease I wash out the uterus once thoroughly in order to remove what septic material might be found there. After this if there is any fetid discharge vaginal douches are used every three hours. Two large rubber ice-bags are placed on the abdomen and kept well provided with ice. But the chief remedy is opium. This is preferably given by the mouth, in one-eighth to one-fourth grain doses, frequently repeated so as to keep the patient free from pain. Brandy and whiskey are also used freely to counteract the effect of the ice and the opium. As to diet only milk and beef tea are given. The bowels are usually left undisturbed;

though at times it thought best an enema may be given.

OPERATIVE TREATMENT IN INTESTINAL OBSTRUCTION.—In the first Harveian Lecture (*Brit. Med. Jour.*), Mr. Thomas Bryant lays down the following rules for operative treatment :

1. Laparotomy should be undertaken as soon as the diagnosis of acute intestinal strangulation is made. There should be no delay allowed for the formation of a specific diagnosis of its cause. It should likewise be proposed in all cases of acute intussusception, and of chronic, which have failed within three, or, at the most, four days, to be relieved by other treatment.

2. In all operations of laparotomy, it is to the cæcum that the surgeon should first advance, since it is from it he will obtain his best guide. If this be distended, he will at once know that the cause of obstruction is below ; if it be found collapsed, or not tense, the obstruction must be above. Adhesions or bands are, moreover, more frequently near to, or associated with the cæcum, than with any other part of the intestinal tract. It is also in the right iliac fossa that the collapsed small intestine, in cases of acute strangulation, is usually to be found ; and, with this as a starting-point, the surgeon will have less difficulty in tracing up the intestine to the seat of strangulation than if he begins at a distended coil, when it will be a matter of chance whether he travels away from or toward the special object of his search—the seat of obstruction.

3. In a laparotomy, when the strangulated coil of bowel is gangrenous, it should be brought out of the wound, and the gangrenous knuckle resected. The proximal and distal ends of the resected bowel should then be stitched to the edges of the wound, and an artificial anus established.

4. Nélaton's operation of enterotomy should be undertaken in all cases of intestinal strangulation, when laparotomy is rejected or seems inapplicable, as well as in cases of intussusception in which the invaginated bowel cannot readily be released. It should be performed in the right groin, or, rather, right iliac fossa.

5. If laparotomy succeed, the cause which called for it is removed, and the normal action of the bowel is restored. If resorted to early, and as a rule of practice, it is probable that it would be more successful than the treatment by opium, inflation, or purgatives, which has hitherto been in vogue.—*Med. and Surg. Reporter.*

TELESCOPIC CATHETERIZATION.—Dr. A. E. Dugas, of Augusta, Ga., sends us an account of a method employed by him in cases of retention from so-called impermeable stricture of the urethra. He takes the largest sized gum-elastic catheter which will enter the meatus, passing it down until

arrested at the narrowed portion of the urethra. It is then withdrawn cut off just above the eye, the edges smoothed off, and then reinserted. When it has passed as far as it will go the end is cut off about an inch from the meatus, and the rest of the tube tied so as to prevent slipping from the canal. Now another catheter is chosen of a size that will just pass through the one *in situ*, and is inserted as far as it will go. It will probably pass farther than the first one, but if not, a smaller size must be selected. If this do not enter the bladder it is to be passed as far as possible and then the eye cut off as in the first case. Now a third catheter passed through number two will almost surely enter the bladder, except in the very worst cases. The larger or outer instruments serve, Dr. Dugas states, not only to ward off and exhaust the contractions of the urethra, but also to act as a stiff handle to direct and guide the smaller and more flexible instruments passing through them.

In connection with this subject the writer states his belief that a great many more cases of retention of urine are due to some derangement of the kidneys than to the urethra. And he says that he has "frequently relieved such cases like magic by a dose of nitrate of potassa, say ten or fifteen grains, twice a day or oftener. The trouble is not that there is too much water in the bladder, but that what water is there is very irritating, and the urethra being more or less strictured revolts against its passage."—*Med. Record.*

RADICAL CURE OF HERNIA.—In one of the latest attempts to effect by operation the radical cure of hernia the "invagination" method has been neglected in favor of procedures aiming either at obliteration of the whole sac or simply at direct closing of its neck. A portion of Sir William MacCormac's surgical address at the meeting of the Association at Belfast was devoted to this subject, and several cases were recorded therein of successful excision of the sac. Professor Stokes advocates an operation consisting in the insertion through the incised neck of the sac, near to the external ring, of one or more catgut sutures, and the subsequent approximation of the pillars of the ring by sutures of stronger and more durable material. Mr. Barton of Dublin, cuts down on the neck of the sac, and brings the pillars of the ring together by strong silver wire, which he allows to remain. Torsion of the sac is recommended by Mr. Ball, of Dublin, who, in a paper read before the Section on Surgery at Belfast, gave details of a case in which, after having exposed the neck of a large scrotal tumor, and separated it from the cord, he twisted this portion of the neck with some force.—*Brit. Med. Journal.*

TREATMENT OF BURNS BY BORACIC ACID OIL.—C. J. Bond, F.R.C.S., (*Brit. Med. Journal*) writes as follows : It is now a year since we began

to use boracic acid oil as a dressing for burns at the Leicester Infirmary, at first simply in the form of a mechanical suspension of the powdered acid in olive oil. I have found that 18 grains of powdered boracic acid dissolved in a drachm of hot glycerine, and added to an ounce of olive oil, forms a kind of imperfect emulsion, the glycerine retaining the acid in solution when cold. This can be easily shaken up with oil. This makes a non-irritating and doubly antiseptic dressing, and extensive burns treated thus, and covered with a layer of some antiseptic wool, require to be disturbed but seldom, and if not perfectly aseptic, are far "sweeter" than when dressed with, for instance, the carron oil. As a lubricant for catheters, sounds, etc., this boracic oil with glycerine possesses advantages. It is superior to olive oil because of its antiseptic property; and better than carbolic oil, because it is less irritating and much more stable, boracic acid being non-volatile. Glycerine itself, too, is a dressing of considerable value by virtue of its dehydrating power.

PRURITUS VULVÆ—There is probably no complication of pregnancy which so much annoys the woman as pruritus of the vulva. So persistent is it at times as to even cause serious mental depression, and the remedy which shall promptly relieve it is a great boon. Dr. Atthill, of Dublin, recommends the following lotion :

R. Acid carbolici, gr. xx.
Tr. opii., ʒ ss.
Acid hydrocyanici dil., ʒ ij.
Glycerini, ʒ ss.
Aquam q. s. ad., ʒ iv.—M.

Sig.

This is to be applied to the parts by means of a pledget of cotton thoroughly saturated with it and left in contact with the parts. The same lotion, similarly applied, is said to be also useful in pruritus ani.

We have found the application of essence of peppermint to be an efficient remedy. It must be carefully and gently applied at first, and if the smarting which it causes be very severe it may be diluted with an equal quantity of alcohol.

The British Medical Journal alludes to the use of balsam of Peru in this connection as a new triumph in medicine. We had occasion recently to apply it in a case of intolerable pruritus of the vulva, in a woman in the seventh month of pregnancy. The effect was exceedingly satisfactory. It is said to be equally efficacious when the anus is similarly affected. A pledget of cotton is saturated with it and allowed to remain in contact with the parts.

A physician with whom we recently conversed on this subject, declared a saturated solution of borax in laudanum, to be an infallible application, in his experience.—*Medical Age*.

DISPENSARY ADVANTAGES IN PHILADELPHIA.—The dispensary advantages are so extensive in this city, that the poorer and sometimes even the middle classes are enabled to get good medical and surgical advice without pay. Since the two institutions for advanced medical learning have been established, there is not clinical matter to go around. It is now no uncommon matter to find "interesting cases" hiring themselves out at rental ranging anywhere from twenty-five cents to two dollars per lecture, and if this goes on, the possessor of a well marked case, say, for example of lupus, may regard his face as his fortune.—*Phila. Med. Times*.

AN EXCELLENT COUNTER-IRRITANT.—Dr. Ellwood gives the following in the *New England Med. Monthly*: Some years ago I saw the following counter-irritant in one of the medical journals (which one I now forget), and which in certain classes of cases I have found very beneficial :

R. Oleum Tiglii..... ʒj
Ether Sulph..... ʒij
Tr. Iodine..... ʒv—M.

S.

This excellent counter-irritant is applicable where it is not necessary to produce too much effect. It is particularly nice for children.

REMOVING A CINDER FROM THE EYE.—Dr. Deming in the *New England Monthly* says: Recently while riding in the cars, I was unfortunate enough to get a cinder in my eye. After vainly trying to extract it myself I went up to one of the brakemen and asked him if he could remove it for me. He lifted the lid and catching sight of the little foreign body, he said very quickly, "O yes!" and pulling from his head a long hair he made a loop of it and passing it over the conjunctiva, quickly removed the particle. The manoeuvre was so simple and successful and to me new, that I thought it worth sending to your monthly.

SURGICAL FEVER.—The *Coll. and Clin. Record* gives the following as a mixture used in surgical fever, at Jefferson College Hospital :

R Liq. ammon. acetat.,
Liq. potass. citrat., aa ʒj,
Spirit. æth. nit.,
Liq. morph. sulph., aa ʒss.—M.

Sig.—Dessertspoonful ter die.

If the fever runs very high, grt. ij tinct. aconit. rad. are added to each dose.

OSMIC ACID IN SCIATICA.—Osmic acid is recommended by James Mercet, M. R. C. S., in the *Lancet*, for sciatica. From three to five minims of a one-per-cent solution is injected by the hypodermic syringe deeply into the parts over the course

of the nerve midway between the tuber ischii and the trochanter major. There may be slight numbness following. In some the effect was marvellous. Out of eighteen cases twelve were given relief for several weeks, when they passed from under observation.

THE TREATMENT OF SICK-HEADACHE.—Dr. W. Gill Wylie, of New York, has produced excellent results with the following method of treatment: So soon as the first pain is felt, the patient is to take a pill, or capsule, containing one grain of inspissated ox-gall and one drop of oil of gaultheria, every hour until relief is felt, or until six have been taken. Dr. Wylie states that sick-headache as such is almost invariably cut short by this plan, although some pain of a neuralgic character remains in a few cases.—*N. Y. Med. Journal*.

REPETITION OF IODINE INJECTIONS IN HYDROCELE.—Professor Tillaux drew the attention of his class, at the Beaujon, to the danger of being in too great a hurry in repeating injections of iodine in hydrocele. It is only at the end of six weeks or two months that we can judge of the result of the first injection, and to interfere before this time is to expose oneself to induce the formation in the tunica vaginalis of those false membranes which are so vascular that they bleed on the slightest shock, and thus give rise to hæmatocele and the loss of the testicle.—*Med. and Surg. Reporter*.

CRYSTAL PEPSIN.—The surgical value of pepsin as a dissolvent is well shown in a note in the *North-Western Lancet*. The editor of that journal states that he was once called upon to relieve the distress occasioned by a bladder distended with clotted blood. He injected a scruple of Jensen's crystal pepsin in an ounce of warm water, and had the satisfaction of seeing the patient pass a full stream of urine and disintegrated blood, in less than twenty minutes.—*Med. and Surg. Reporter*.

THE RELATIONS BETWEEN PHYSICIAN AND PATIENT.—A recent number of the *Lancet* contains a thoughtful editorial upon this subject, called out by an unjust charge against a medical gentleman. The subject is a delicate one, but the writer has approached it in a most careful and unobjectionable manner. It is not wholly unnecessary to remind physicians that they never can be too cautious in dealing with a certain class of women, who maliciously involve an innocent man in lasting disgrace. The recklessness with which some of the younger men allow themselves to treat pelvic diseases, without providing the smallest loop-hole for escape in case of unjust accusations, is a constant matter of surprise to those who have learned caution from experience. Short visits, entire absence of familiarity, and a refusal to undertake any pro-

cedure in a questionable case without the presence (or knowledge) of a third party—these are the only safeguards. "It is usually advisable to avoid mixing social with professional visits," says the article to which we allude; "a doctor visiting *as a doctor* should play the doctor and not the visitor; he may visit *as a visitor* at another time. In cases of domestic unhappiness or separation he should be doubly cautious."

Enough has been quoted to show the tenor of the remarks. No man who follows out these precepts can fail to conduct himself on every occasion in a manner worthy of the honor and dignity of his profession.—*N. Y. Med. Jour.*

OAKUM AS A SURGICAL DRESSING.—By Robert Leslie, M.D., Belfast (*Brit. Med. Journal*).—Oakum is made from old ship's rigging which has been soaked in tar, and then reduced to its original state of flax or hemp. During the American war oakum was extensively employed in the field hospital as a surgical dressing.

Eight years ago I commenced to use this dressing in the Children's Hospital. Since that time oakum has been in use in all the hospitals of Belfast, and by some is now considered indispensable. I have been using oakum for burns, erysipelas, ulcers, abscesses, and many vaginal displacements; and I think it the best ready-made dressing we possess. One of its advantages is that it keeps down offensive odors. The serum from a wound is drained as it is discharged, and pleasant tarry smell is a great contrast to the offensive odor common in connection with lint.

In amputation it forms a soft and comfortable pad for the stump, and is a good vehicle for the application of antiseptics. In the treatment of abscesses it takes the place of a poultice by dipping it in warm water and covering with waterproof tissue. Its application, after opening an abscess, permits the easy escape of pus, and is conducive to quick healing. In erysipelas I envelope the affected part in oakum, and with such good result that I do not seek another agent.

As to dressing for burns and scalds I look upon oakum as invaluable. It may generally be applied to the granulating surfaces with impunity, and is more easily detached than almost any other dressing. I thus account for the fact: when a dry fibre of cotton is placed beside a fibre of linen under the microscope, you perceive that the cotton is round and smooth while the linen is sharp and angular but on the application of water the case is different. The cotton fibre is found to twist in a spiral manner, while the linen fibre is unmoved. It is a popular theory that cotton does not form so good a dressing as linen, and this hygroscopic difference may account to a great extent for their difference in behaviour when applied to moist surfaces, and the ease in removing linen.

In uterine and vaginal affections oakum can be turned to good account. The healthy effect of this tarry substance applied to the mucous membrane of the vagina is most remarkable. A tonic effect is produced, and the unhealthy discharge is absorbed. In prolapse and other displacements of the uterus when it is difficult or impossible to get pessaries to relieve, you can secure twenty-four hours' respite to your woman by filling the vagina with oakum, and by dipping the first plug in glycerine you gain immensely in cases of subinvolution from the quantity of fluid extracted.

To sum up: oakum is a handy, healthy, and cheap dressing. It is easy to apply, and I think it is antiseptic in the sense of forming a barrier to the ingress of germs to the part to which it is applied. Tar is itself a wholesale agent, a substance of complex composition. It contains creasote, turpentine, paraffin and eupione, and is obtained by the destructive distillation of *pinus sylvestris*. Carbolic acid has largely taken the place of the cruder compound, but Dr. Whitla says the virtues possessed by tar are not equally enjoyed by its more fashionable rivals. In oakum we have a form of tar dressing which I recommend to those engaged in hospital work.

NEW MODE OF LOCALIZING BULLETS.—In the transactions of the Vt. Med. Soc., Dr. S. J. Allen says:

"Perhaps I may be pardoned if I say, that during the four years of the war I served in the field one year as surgeon of a regiment, two years as Surgeon-in-Chief of a division, and last year as Medical Inspector of the Sixth Corps, and must have seen and examined, if not treated, many gunshot wounds. In all I have examined, be they more or less in number, I never localized a dozen bullets with a probe.

"In nearly all not localized by the finger or sense of touch, I succeeded in fixing with certainty their exact location by the use of the exploring needle.

"I claim that if the bullet did not enter either of the cavities of the body, but lays anywhere in the periphery among the muscles, or other tissues exterior to them, the exploring needle, in the hands of the surgeon, will, by puncturing a reasonable number of times, hit the ball, and convey the intelligence of its exact location.

"Had the exploring needle been used in the case of our late President, the 'encysted wall of pus in the right iliac region' would have been punctured without appreciable resistance, and his surgeon saved the Blissful diagnostic error contained in several of their bulletins, which located the fatal bullet at that exact point with absolute certainty.

"A serviceable instrument for this purpose will be found in the smallest sized exploring needle,

with which, all will admit, it is quite safe and comparatively painless to make the puncture.

"It is not unusual to puncture not only the peritoneal cavity, the pleural cavity, and the bladder, but the intestines, and the pericardium, and seldom has harm resulted.

"The probe should be used only to determine the direction the ball took from its point of entrance, and to ascertain if it entered a cavity. Here, I claim, its usefulness ends, and if further used does harm.

"The surgeon almost always has an impression, after an examination, that the ball lies at a certain point. To test this impression, push the exploring needle from the surface directly down to this point. If it does not hit the resisting bullet, try at the next most likely point. If not successful try again. The bullet can be localized in this way many times where all other methods fail. When the needle hits the ball, the surgeon will make the counter incision for its extraction with perfect confidence.

"Supposing that the bullet lies in close proximity to a bone, or is flattened upon a bone, by using a little more force, the point of the needle will be made to penetrate the ball slightly, and will stick a little, and thus convey to the surgeon's hand a sensible difference between bone and lead."—*Med. and Surg. Reporter*.

A POINT IN THE EARLY DIAGNOSIS OF PREGNANCY.—The *Medical Chronicle* quotes from a paper published by Hegar, in the *Prager med. Wochenschrift*, to the effect that this writer has noticed what he considers an important early sign of pregnancy. Hegar calls attention to the fact that during pregnancy the lower uterine segment becomes thinner and softer than in the non-gravid organ. This condition can be made out easily by bimanual palpation, especially if one finger is placed in the rectum while the uterus is depressed from above with the other hand. The sign is said to be nearly constant, but its absence is by no means a proof that pregnancy does not exist.—*N. Y. Med. Jour.*

NEUTRAL MIXTURE FOR FEVERS—Prof. Brinton speaks highly of the following neutral mixture in fevers of moderate type. R. Liquor ammonii acetatis, ʒ j.; liquor potass citratis, ʒ j.; spiritus ætheris nitrosi, ʒss.; liquor morph sulphatis, ʒ ss. M. Sig. Two teaspoonfuls three or four times a day. If the fever is of a higher type, and the pulse full and bounding, tinctura aconiti radidis ℥xii.—xxiv. may be added to the mixture with advantage.—*Med. Bulletin*.

ERGOT IN CONSTIPATION—In the *Allgemeine Med. Zeitung* (Medical Press), Dr. Granzie reports two cases of constipation following the abuse of purgatives cured by ergot. Three doses of ten grains

each were given at intervals of two hours and were followed by copious evacuation. A second stool occurred spontaneously the next day, and after the administration of ergot in small doses for a few days a definite cure was obtained. The constipation was due to atony of the muscular wall of the intestines.—*Louisville Med. News.*

LINIMENT FOR RHEUMATISM.—The *Therap. Review* says: Methyl salicylate (oil of wintergreen) mixed with an equal quantity of olive oil or linimentum saponis, applied externally to affected parts in rheumatism, affords instant relief, and having a pleasant odor, is very agreeable.

Dr. A. L. Loomis says: "A man can take two or three glasses of stimulants through the day as he may feel the inclination, and he may continue this habit for perhaps 25 years without any evident harm accruing from it; but when this man reaches that period of life when the vital powers are on the decline he suddenly finds himself old before his time, for he has all these years been laying the foundation for chronic endoarteritis. I believe, gentlemen, that 50-per-cent of all diseases arise from the use of alcoholic stimulants.

Erichsen says: "The practice of operating in notoriously hopeless cases with a view of giving the patient what is called 'a last chance' is much to be deprecated and should never be followed. It is by operating under such circumstances, especially in cancerous diseases, that much discredit has resulted to surgery; for in a great number of cases the patient's death has been hastened by the procedure which instead of giving him a last chance, causes him only to be despatched sooner than he otherwise would have been."

There are four plans for reducing obesity. 1. The eating of nothing containing starch, sugar or fat, called the Banting system. 2. The eating of fat but not sugar or starch, called the German Banting. 3. The clothing in wool and sleeping in flannel blankets instead of sheets, the Munich system. 4. Not eating and drinking at the same time, or rather with a couple of hours between the eating and the drinking, the Schwenger system.—*Detroit Lancet.*

The oldest physician in the world, Dr. C. C. Graham, died at his home, in Louisville, on Tuesday, the 3rd inst. He celebrated his one hundredth birthday on the 10th of October, 1884. He was the last link which bound the pioneers of Kentucky to the present generation. A man of remarkable physical and mental power, he practiced his profession for a period equal to the lifetime of the average physician, and spent his old age in scientific and literary pursuits.

Chloral hydrate is recommended as a substitute for cantharides, as a vesicant. Sprinkle powdered chloral on ordinary adhesive plaster, melt it with a gentle heat and apply to the part. In ten minutes vesication will be complete. Its advantages are rapidity of action, less pain, freedom from danger of absorption of cantharidin, and the plaster may remain on until the sore is healed.

PAPINE.—Dr F. O. Young, of Lexington, Ky., says; I have used Papine in my practice and have taken considerable pains to test it and watch its action. I think it superior to any preparation I ever saw used containing opium. It is safe and pleasant and in no case did it ever produce the least nausea.

Dr. James E. Baker (*Med. Record*) recommends cocaine in phthisical cough. Five minims of a four per cent. solution, with a like amount of chloroform, are dropped upon an inhaler and taken at bed time. In two cases of this kind he succeeded in giving the patients a better night and making them more comfortable than he had been able to do by any other mode of treatment.

Dr. Forrest in the *Medical News* reports excellent results in a severe case of dysmenorrhea from the hypodermic administration of five minims of a 4 per cent. solution of cocaine. Complete relief was afforded for five hours, and comfort for a much longer time.

—Syphilitic condylomata dwindle away visibly on application three times a day of the following powder dusted over the new growths:

R. Hydrarg. subchloridi,	- - -	gr. xxx.
Acid. Boracic,	- - -	gr. xv.
Acid. Salicyl,	- - -	gr. v.

Chloral hydrate is said by Dr. Roberts Bartholow to be the incomparable remedy for cholera. In many cases of cholera infantum it certainly is of great service.

Dr. F. N. Otis (*Med. Record*), says that he has recently given for three months twelve drachms of the iodide of potassium every twenty-four hours to a patient suffering from syphilis. Entire relief followed from all dangerous symptoms.—*Detroit Lancet.*

To remove foreign bodies from the ear Mr. Jonathan Hutchison recommends the introduction into the ear of a loop of small flexible silver wire. This being hooked about the foreign body, permits of its ready extraction.—*Detroit Lancet.*

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science
Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 29 Rue Richer, Paris.

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The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

THE TREATMENT OF ASTHMA.

The ordinary physician is prone to regard chronic disease as a thing to be endured rather than cured. Especially is this true in the case of asthma. Why the case of the unfortunate asthmatic should be passed over more lightly than that of sufferers from other chronic diseases, finds an explanation in the notoriously unsatisfactory results of treatment, and the patient's almost certain tenure of life, for the time at least, despite his suffering. When, however, we reflect on the number of asthmatics, and the misery they endure, such indifference is both irrational and cruel. We desire, therefore, to call attention to the nature of the disease, the misery it entails, and the ineffectiveness of common routine treatment, in the hope of stimulating a spirit of more exact enquiry, both as regards etiology and treatment.

Research, and the application of remedies, in any certain direction, usually bear some relation to the importance of the disease undergoing investigation. Here is a disease which afflicts, more or less seriously, millions of the human family, causing much bodily and mental suffering, incapacitating for work or business, and shortening life, yet the physician with all his boasted knowledge has to confess that he is almost powerless to cure, and, at best, only hopes to afford his patient transient relief. We all know how true this is, and how disheartening to the sufferer. He who suffers from chronic consumption, chronic bronchitis, inveter-

ate skin disease, or other troubles equally obstinate, receives more encouragement and comfort at the hands of science than the poor asthmatic. This is all the more strange when we consider that idiopathic asthma is not marked by structural change. This of itself, of course, amounts to nothing, as what at first sight appears simple and easy of accomplishment, on closer examination, may turn out complex and difficult to conquer. Nevertheless it is almost certain the asthmatic has received but scant justice at the hands of the profession. His case has not been examined with due care—causes, immediate and remote, have not been closely inquired into, and he has been altogether too hastily consigned to the limbo of incurables.

It is not sufficient to know that our patient is suffering from asthma. Before we ever attempt to cure him, or afford him transient relief, some important enquiries are essential. This will appear all the more necessary when we remember that the disease is seldom truly idiopathic, but is generally associated with, or dependent upon some other trouble. True, the vast majority of cases may be relieved off-hand, for the time, by one or more of the stock prescriptions for asthma, without any close scrutiny of the case. It is just here where the common error in the treatment of asthma begins. If the attack be the first, or the disease have not yet so far advanced as to have ingrained itself, so to speak, into the patient's constitution, the more culpable is such hap-hazard treatment, since a clear apprehension of the case at the outset might have led to a different and more successful course of treatment. *Cure*, and not temporary relief, should be our aim in all recent cases, especially in the young. To say that asthma is incurable is to utter an absurdity. Some cases are cured spontaneously; some by physiological changes in the constitution; others by a change of residence, and, we hope, not a few, by medical treatment. There can be no doubt, however, that the great majority of chronic cases are incurable, and that the best we can do has no lasting beneficial effect. But even here it is proper to discriminate in order to a choice of remedies in individual cases.

Asthma essentially consists in a spasm of the bronchial muscles which surround the smaller air tubes, with simultaneous congestion of the bronchial mucous membrane. The asthmatic will tell

us that his difficulty lies not so much in his inability to take in air, as to expel it. Asthma is sometimes secondary to bronchitis—hence some writers divide spasmodic asthma into two divisions, *idiopathic* and *bronchitic*. A broader division is indicated by *idiopathic* and *symptomatic*. To be able to class any individual case in one or other of these divisions will afford some definite data for treatment. The purely spasmodic case, if such there be, will require management differing from that classed as bronchitic or symptomatic, and *vice versa*. Sight should never be lost of the fact that asthma is often the result of reflex action, the seat of origin being the brain, lungs, stomach, or other organ, frequently requiring for its location much patience and skill. From these observations it will be seen that the proper diagnosis and treatment of asthma is not by any means so light a task as many seem to think. The observance of these, and other points that will readily occur to the thoughtful practitioner, would do a good deal towards lifting the treatment of asthma out of the domain of empiricism, which has always been its bane, to a basis as rational and scientific as that on which rests the treatment of many other disorders.

As to the remedies recommended in the books for this disease there is no end. With no intention of depreciating the value of several old and well tried remedies, we shall now only refer to agents which have recently forced themselves to the foreground. Of these perhaps citrate of caffeine stands first. The dose is one to five grains, dissolved in warm water. It does not appear to be a very dangerous agent, since, in one instance, a patient took 60 grains by mistake, without fatal consequences. Caffeine is said to afford very prompt relief. Arsenic, in the form of 2 or 3 minims of Fowler's solution is reported as making striking cures in appropriate cases. Arsenic has the peculiar property of supporting respiration, as, for example, in making ascents. Its beneficial effect in asthma is no doubt due to this property. Iodide of potassium, is sometimes combined with Fowler's Solution. A valuable combination in the bronchitic form is iodide of potassium, and carbonate of ammonia. Chloral hydrate, either alone or in combination with bromide of potassium, is also followed with excellent results in certain cases. In the form of stagnant respiration with congested

lips and nose, and cold extremities, strychnia has been found highly useful. The liquor may be given in doses of from 3 to 5 drops with dilute phosphoric acid. When defluxion from the mucous surface is very profuse, belladonna probably answers best. Medium doses should be given every 4 hours. Grindelia robusta a short time ago was largely used; but failed to come up to expectations, and is now much less used. Quebracho is also a remedy in much répute. We occasionally meet cases of continued distress despite the use of ordinary means. In these cases there is usually much bronchial tumefaction and dryness. In cases of this class nothing can equal one-fourth grain of pilocarpine, with one-fourth grain of morphine, administered hypodermically. The relief is prompt, the tumefaction subsides, and is followed by profuse expectoration. As to change of climate, experience shows that the asthmatic should not seek a dry atmosphere, such as that of Colorado, and the West generally. On the contrary, a warm, moist atmosphere is the most suitable. In mild cases a mere change from one locality to another may create immunity from this harrassing trouble.

THE PREVENTION OF CHOLERA.

With the advent of Spring and summer, the invasion of cholera may be looked upon as one of the probabilities, and therefore the authorities should set about preparations as actively as possible for its prevention. There may be still some doubting Thomases who cannot believe that sanitary measures are of any avail to protect the people from these so-called visitations of Providence. We trust however, that the authorities will not be influenced by any such foolish notions, but will put into vigorous action all the sanitary resources of the country, with the view of stamping out the first approach of cholera to our shores.

If anything were wanting to show the great value of sanitary measures in stamping out this scourge, it will be found in the experience of the city of Genoa, during the prevalence of cholera in in France and Italy. The United States consul at Genoa in a communication to the Home Government on this subject, gives the methods adopted there from which are transcribed the following:

He says: "Since the outbreak of cholera at Toulon and Marseilles a continual purification of

streets, alleys, private and public houses, has been kept up, the most powerful disinfectants being used for the purpose, which made the city all summer, as it is to day, one grand smelling-bottle, of sulphur, chlorine, etc. Impure water, or water supposed to be impure, was shut off from the city; stale fruits and vegetables were seized and destroyed; this year's wine crop was not allowed to be brought into Genoa, and all the wine shops were forced to be closed at 8 p. m., daily. The rules were rigid in regard to household cleanliness, and the use of disinfectants in whitewash, and if the owner of an establishment of any size heeded not the orders of those in authority the work would still be performed, and at the expense of the proprietor. In three hundred cases of cholera before the Aqueduct Nicolas was shut off from the city, there were two hundred and seventy-five deaths, and all the victims had been using this water. Since the water was shut off from the city, the cases were few among those who could obtain good wholesome food. The Sunday excesses among the laboring classes proved a powerful feeder of the epidemic. From this fact it appears that regular habits of work or play are essential in avoiding cholera. The doctors all said that substantial food proved a better means of battling with cholera than doctors' medicines."

The Consul seems especially to consider that above all things pure water is essential in the battle with the enemy. In this contention he will be sustained by all who have given any attention to the subject. In his concluding remarks he says:

"Let a city or town have officials who energetically and fearlessly fight everything which has a tendency to prey upon public health, granted the people abuse not nature; let substantial food be one's daily portion; to these things add a frame of mind prepared to face calmly and bravely whatever trials and vicissitudes may cross one's path, and you have an armor that will, I am positive, in nine hundred and ninety-nine cases in a thousand baffle the type of cholera which has lately raged in Genoa.

MEDICAL HEALTH OFFICERS.

The position of medical health officer of a large city is one of great responsibility and requires the

possession of the highest qualities in the individual who accepts it. The incumbent must be a man of good tact and judgment, skilled in his profession, and well versed in sanitary science. Such men are rarely available, especially in view of the miserable salary usually paid such officers in this country. In this city for example, with a population of one hundred thousand, covering an extensive area, with unsanitary conditions in abundance, and sufficient work to keep a medical officer constantly employed, the incumbent (Dr. Canniff) a gentleman eminently qualified for the discharge of the duties appertaining to the office, receives the paltry sum of \$1500 per annum for his services, from the city council, and even this small amount is given grudgingly. A supplementary sum of about \$600 per annum is also received by him from the Dominion Government for extra work in the compiling of Vital Statistics; but certain members of the council, with a niggardliness which is characteristic, propose to deduct the amount received from the Dominion Government, from the sum which was agreed upon as his salary (viz. \$1500). These gentlemen might with the same propriety deduct from his regular salary the amount received by the city clerk for similar work done for the Ontario Government.

We hope and trust that this has not been the the experience of health officers in other cities, for if such is the case we pity them. The gentlemen who have abandoned their private practice to engage in the important and onerous duties of medical health officers, in our large cities, deserve better treatment at the hands of the civic authorities. The services of the medical profession when required must be estimated at their proper value, and the sooner the civic authorities recognize this fact the better it will be for all concerned. No medical practitioner with the proper qualifications for so important an office should be expected to perform duties which require the whole of his time, without receiving at the very least a salary of \$2500 per annum. The recent changes in the Ontario Board of Health entail considerable extra work upon the health officer, and the entire duties appertaining to the office demand the whole of his time. He should therefore be properly remunerated. For the credit of the council of this enterprising city, we trust that no spirit of niggardliness will prevent the present incumbent from receiving that just compensation which is so clearly his due.

THE "STRATFORD" HOSPITAL, BRANTFORD.

The opening of this noble charity took place on the 19th ult., and was made the occasion of a very interesting gathering. Among those present were the Lieut. Governor Robinson, of Ontario, and Mrs. Robinson, Col. Denison, Judge Sinclair, Dr. Chas. O'Reilly, Medical Superintendent of the Toronto Hospital, Dr. W. T. O'Reilly, Inspector of Prisons, Mayor Scarfe, of Brantford, and others. The ceremony of presenting the Hospital to the city was performed by the Lieut. Governor. An address was read by Mr. Stratford, the donor, welcoming the guests and referring to the substantial character of the building and its adaptability for the purpose intended. There will be accommodation for from 40 to 50 beds. The building is well appointed in every respect, and especially as to bed-space, sanitation, drainage, etc. He publicly acknowledged the receipt of many valuable suggestions from Dr. Chas. O'Reilly, of the Toronto Hospital, Dr. Digby of Brantford and others. One of the conditions of the gift is as follows:—

"The management of the hospital shall be strictly non-sectarian in its character and the institution be open to all citizens of the city, subject of course to the rules that may be laid down hereafter for its conduct; that no clergyman, priest, or member of a religious sect or other society shall hold religious or other services within its walls or grounds, except a patient shall request the attendance of such, and then only for that patient's personal benefit. He said "that it was not without the most serious consideration, and after making many enquiries from those who had been and were connected with hospital working, that he appended this condition. Hospitals were purely for the relief of the sick and wounded. Cases admitted therein were mostly serious and required urgent and careful attention. If the patient is insensible he cannot require spiritual advice, but if sane, it is he himself who should say if he wants religious ministrations. Under this condition the patient has full power to send for any adviser as may wish, but otherwise no religious adviser will be allowed to interfere with him. A Medical Superintendent of a large hospital, to whom he had submitted this condition, said:—'I fully approve of it, and it would be better for the proper working of every

hospital were such a rule rigidly enforced, and it is becoming the hospital law in hospitals where it does not already obtain, and where circumstances will admit of its introduction.'"

The Mayor thanked the donor in the name of the city; and the Governor, after some appropriate remarks, declared the hospital opened. At the conclusion a reception was held and the visitors exchanged cordial greetings with the citizens. The band of the Dufferin Rifles furnished the music for the occasion. We cannot conclude our remarks without again referring to the noble generosity which prompted this act, and it is to be hoped that the example will be followed by wealthy and benevolent persons in other cities in Canada.

THE CHOLERA.—The Medico-Chirurgical Society of Montreal held a special meeting on the 13th ult. to discuss matters relating to the prevention of cholera, and the proposed health bill for the Province of Quebec. The meeting which was a very interesting one was largely attended. Dr. Larocque, city medical health officer, read a short paper on the subjects for discussion. Dr. Howard said that the Dominion Government should enforce the quarantine regulations; but it remained for the local government to see that proper sanitary laws were enacted and enforced. Dr. Hingston deplored the absence of any health law, and recommended the adoption of the Ontario Act with certain improvements.

CHILDREN IN LOS ANGELES.—Dr. Lindley in commenting on the low death rate among children in Los Angeles says:—The reasons for this light mortality are: 1. The diurnal breeze from the ocean, which constantly purifies the atmosphere; 2. The constant ripening of fruits—oranges and lemons in the winter; apricots, nectarines, peaches, and berries in the spring; apples, pears, and grapes during the summer and autumn, and strawberries all the year round; 3. Every variety of vegetables fresh each month in the year; 4. The great number of clear days which, "renders possible an outdoor life almost every day in the year."

CHRONIC BRIGHT'S DISEASE.—Dr. H. Corson writes in one of our exchanges that after all the usual remedies now in use for the treatment of Bright's disease had failed, his patient having been

considered beyond recovery, he resorted to a treatment practiced many years ago. The patient was put upon a pill of calomel, digitalis, and squills, of each one grain, to be given three times a day. Morphine, chloral, or both combined, were given at night to relieve pressure and procure sleep. After keeping the system moderately under the influence of the calomel for two or three weeks, the symptoms rapidly disappeared.

STANDARD DISINFECTANT.—In an article in the *Medical News*, January 10th, '85, Dr. Sternberg, U. S. A., suggests a combination of permanganate of potassium with the bichloride of mercury, for common use as a disinfectant and deodorizer. The color of the solution would be a safeguard against its being accidentally drunk. No chemical reaction takes place when these substances are combined; in other words they are perfectly compatible. A solution of two drachms of each of these salts to a gallon of water would be strong enough for all practical purposes. This gives about one part of each to 500 of water.

EXCURSION TO EUROPE.—A number of attractive excursions during the coming Spring and Summer are announced by Messrs. Thos. Cook & Son, the well known tourist agents of New York and London, which are arranged on the most popular scale of prices. Full programmes of these trips, with maps showing the *routes* followed, are to be found in their monthly paper, *Cook's Excursionist*, published at 261 Broadway, New York, which they announce will be sent by mail to any one interested, on application.

NEW YORK STATE MEDICAL SOCIETY.—This society held its seventy-ninth annual meeting in Albany on the 3rd, 4th and 5th ult. under the presidency of Dr. Sherman of Ogdensburgh. The attendance was, as usual, very large and influential and the proceedings most interesting and instructive. We give a brief synopsis of some of the papers read in another column. The most important event of the meeting was the discussion of a bill to be presented to the Legislature for the establishment of a State Examining Board. A satisfactory decision was arrived at, and it is hoped the bill will become law. The social side of the meeting was well sustained.

SANTONINE.—It has been demonstrated that lumbrici live in a mixture of albumen, santonine, and water, but they succumb in a few minutes in an oily mixture of santonine. Experience has proven the necessity of direct contact. Santonine powder or troches is not a good way of administration, for the santonine is then mostly absorbed in the stomach. The only rational preparation is an oily mixture which is slowly absorbed in the intestines. In any other mode it has a toxic effect with many, but given with ol. ricini is not disagreeable, and very efficient.

GUN-SHOT WOUND OF THE CHEST.—Dr. Powers (*N. Y. Med. Journal*, Jan. 10) reports two cases of pistol-shot wounds of the chest. In each of the cases a bullet of large size entered the lung, in the second case passing entirely through it. In neither was the injury accompanied by marked hemorrhage, nor followed by acute inflammation, and in each the patient made a speedy and perfect recovery. But slight attempts were made at probing the wounds. The wounds were not hermetically sealed, but simply dressed with antiseptic dressings, which were continued until the wounds were healed.

THE TELEPHONIC TELEGRAPH.—A new invention of considerable importance has been perfected recently by Dr. Rosebrugh of this city, assisted by Mr. G. Black, of Hamilton, by means of which telephonic and telegraphic messages can be exchanged through long distances on the same wire simultaneously. One important feature of the invention consists in the entire suppression of the induction which is such a nuisance in the ordinary telephone. Telegraphic signals sent over the wire cause no inconvenience to the telephonic listeners.

INFLAMMATORY FEVER.—The following, which is a modification of a formula by Prof. Gross, is recommended in all cases of sthenic inflammation, except where morphine may be contra-indicated:

℞ Liq. amm. acet. ℥iv.
Spt. eth. nit. ℥j.
Tr. aconit. rad. ℥xx.
Morph. sulph. grs. iss.
Aqua. ad. ℥viiij.—M.

Sig.—A tablespoonful every four hours. Liquor potassæ citratis may be substituted in some cases for the liquor ammoniæ acetatis.

ANÆSTHETIC MIXTURE.—After considerable experience in the use of different anæsthetics, Mr. Lawson Tait has come to the conclusion that a mixture of two parts ether and one of chloroform is the safest and most satisfactory. Other surgeons prefer the A. C. E. mixture; alcohol 1 part, chloroform 2 parts, and ether 3 parts. Both the above mixtures are rapid in their action, not unpleasant to the patient, and produce less sickness than chloroform or ether when given alone.

APPOINTMENTS.—Dr. M. Lavell has been appointed Warden of the Provincial Penitentiary, Kingston, and Dr. O. S. Strange, surgeon to the same institution.

Dr. G. Stewart, of Port Rowan, Ont., has been appointed Assistant Surgeon, Norfolk Battalion of Rifles, *vice* G. W. Stewart, deceased.

Dr. M. I. Beeman, of Centreville, Ont., has been appointed Surgeon, Frontenac Battalion of Infantry, *vice* J. McCammon, deceased, and Dr. R. W. Garrett, of Kingston, Assistant Surgeon.

Dr. Jas. Dorland (formerly of Hamilton Ont.) has been appointed Prof. of Practice of Medicine in Milwaukee Med. College Wis.

The following gentlemen have been appointed License Commissioners for the counties named—J. Gunn, M.D., N. Middlesex, C. M. Gould, M.D., East Northumberland. R. Douglass, M.D., N. Bruce, W. H. Blackstock, M.D., East Simcoe. A. Worthington, M.D., West Huron.

OBITUARIES.—The death of Chas. Clay, F.R.C.S., of Manchester, is announced in our exchanges; also M. H. Newmann, Prof. in the University of Breslau.

Dr. E. S. Gaillard, of New York, editor of "Gaillard's Medical Journal," died on the 2nd ult. The Journal will be continued under the management of M. E. and E. W. Gaillard.

Dr. William Braithwaite, of Leeds, Eng., founder of "*Braithwaite's Retrospect*," died on the 1st ult., aged 78 years. He was the oldest medical practitioner in Leeds.

The death of Prof. Elsberg, of New York, the Laryngologist, is announced in our exchanges.

We regret to learn of the sudden death of Mrs. Dr. Winstanley at Los Angeles, Cal., on the 10th ult., formerly of this city.

REMOVAL OF THE OVARIES AND FALLOPIAN TUBES.—Dr. Trenholme of Montreal (*Can. Med. Record*) reports six cases of removal of the ovaries and Fallopian tubes with recovery in each case and with good results so far as relief from the pelvic suffering was concerned. The operations were all performed during the year ending April, 1884.

AMERICAN MEDICAL ASSOCIATION.—The 30th annual meeting of the American Medical Association will be held in New Orleans commencing on Tuesday the 28th of April. This is a most favorable opportunity of visiting the Association and the World's Fair at the same time. The rates of travel to New Orleans from all points are as low as can reasonably be expected.

NEW METHOD OF TREATING ACUTE INTESTINAL OBSTRUCTION.—The London *LANCET*, Feb. 14th, in referring to the new method of treatment states that it was first proposed by Prof. Kussmaul. It consists in free washing out of the stomach and removal of large quantities of fecal matter, and has been attended with excellent results in several cases. The relief from distention is very great, and it also favors subsequent treatment by laparotomy when the latter is necessary.

TREATMENT OF FROST-BITE.—Dr. Doane in the *Therapeutic Gazette*, gives the following prescription which he says is excellent in frost-bite, and hopes it may be given a trial:

R Cosmoline ʒ i.
Spts. turpentine, ʒ j.
Acid carbolic gtt. x.

The cosmoline and turpentine are rubbed up together in a mortar, and the acid dropped in after. This is being prescribed by Dr. James R. Leaming, and many other able men in New York.

TRANS-ATLANTIC CLUB.—A club has been formed recently for the convenience and benefit of Trans-Atlantic students in Edinburgh. The object is to cultivate a feeling of fellowship and secure a means of social intercourse, so that students may not feel themselves strangers in the city or strangers to each other. The rooms which are at 37 Chambers Street will be supplied with home papers and journals.

GRANTING DEGREES IN MEDICINE.—The Uni-

versity of Vermont has announced its intention of granting degrees in medicine to registered British medical practitioners who pass a satisfactory examination in medicine, surgery, and midwifery. The fee to be charged is \$30.

HONORS TO LISTER.—The Emperor of Germany has conferred on Sir Joseph Lister the "Ordre pour le mérite" for Science and Arts. This is not only a testimonial to Lister, but also a generous recognition of the claims of medical science, which Germany has not been slow to recognize.

MEDICAL SOCIETY DINNER.—The first annual dinner of the Hamilton Medical and Surgical Society was held at the Royal Hotel on the 4th ult., and was a most successful and interesting reunion. The profession of Hamilton was well represented by many of its ablest men.

CORRECTION.—In our last issue we noticed among new books the work of "McNaughton Jones on Diseases of Women," giving W. Wood & Co. as the name of the publishers. It should have been credited to D. Appleton & Co., New York, as the publishers.

BRITISH DIPLOMAS.—Drs. J. L. Davison (Trinity) and W. D. Oakley (McGill) have obtained the M.R.C.S., Eng.

Dr. W. G. Hardy (McGill), and W. A. Ross (Toronto), have obtained the L.R.C.P. Lond.

Dr. Osler has been granted leave of absence by the authorities of the University of Pennsylvania, and sailed on the 10th ult. for England, where he is to deliver the Gulstonian lectures in the Royal College of Physicians.

SIGN OF SCIATICA.—An exchange says that if the patient be placed on his back and the suspected limb raised and flexed strongly, a pain appearing about the sciatic notch will be a certain pathognomonic sign of sciatica.

Why is it, considering the high standing of the profession, that medical literature in Canada is at such a low ebb, and that only two Canadian works, Fulton's *Physiology* and Canniff's *Surgery* are in circulation?

What are the requirements for the position of surgeon and assistant surgeon in the British army, and what are the duties, salary, rank in the service, and pension for disablement? Is a Canadian graduate required to take out the M.R.C.S., Eng., before presenting himself as a candidate?

QUEROR.

An answer to the following questions will be thankfully received.

1. Explain how the stomach is enabled to produce an acid secretion from the blood—an alkaline fluid; have we any means or medicines to assist or promote this action, and what are they?
2. When defibrinated blood is injected *per rectum*, why are not the corpuscles absorbed?

DENVER, Col.

TREATMENT OF IMPOTENCE.

Would some reader of the *Lancet* give his views as to the most appropriate treatment for impotence. The patient is a man 56 years of age, married, good family history, no evidence of syphilis, no venereal excesses, never ill in his life.

NEMO.

MEDICINE CHEST.

Would some of the readers of the *Lancet* offer some suggestions for a medicine chest for country practitioners. Many of us have to make long trips far from any drug store and it is desirable that we carry as great a variety of drugs as may be necessary, in as small a compass as possible.

Messrs Stevens and Sons have signified their intention of manufacturing a case that will meet all requirements as suggested at a reasonable price.

MEDICO.

[Would not A. A. Mellier's saddle bags meet the requirements? See advt.] ED.

Notes and Queries.

Will some physician who has obtained L.R.C.P. and S., Edin., give a brief description of his trip, the expenses of the same and the requirements for the degrees?

Books and Pamphlets.

THE AMERICAN SYSTEM OF PRACTICAL MEDICINE. Edited by William Pepper, M.D., LL.D., of the University of Pennsylvania, assisted by Louis Starr, M.D. In five imperial octavo volumes, containing about 1000 pages each, with illustra-

tions. Philadelphia: H. C. Lea's Son & Co. Prices per volume, cloth, \$5.00; leather, \$6.00; half Russia, \$7.00.

The first volume of this magnificent work is now before us, and the other volumes will follow at intervals of about four months. It has been in active preparation during the past three years, and is now sufficiently advanced to justify the publishers in calling the attention of the profession to it as a work in which American medicine will be thoroughly represented by its worthiest and most practical teachers. A reference to the list of contributors will show that the most distinguished men in all parts of the United States have united in bringing together this vast aggregate of specialized experience. It embraces the whole domain of medicine, including the departments for which the physician is accustomed to rely on special treatises, such as diseases of women and children, the genito-urinary organs, skin, nerves, hygiene and sanitary science, and medical ophthalmology and otology. It may therefore be regarded as a complete library of practical medicine. Such illustrations as serve to elucidate the subject have been introduced. It is a work of which every American physician may reasonably feel proud, and in which every practitioner will find a safe and trustworthy counsellor in the daily responsibilities of practice. We are pleased to observe the name of Dr. R. P. Howard of Montreal among the contributors, the subject being rheumatism and rheumatoid arthritis.

A MANUAL OF DERMATOLOGY by A. R. Robinson M.D., Professor of Dermatology, New York Polyclinic. New York: Bermingham & Co. Toronto: Williamson and Co.

This volume the author states is intended to be the basis of a future much larger and more original work, and we think it would have been as well, in view of the many works of this kind now in the market, if the author had deferred the publication until he was prepared with his more original work. The present volume is a mere compilation, but as such, fairly represents the status of the science, and is neither better nor worse than others of the kind. It will be useful to those who would prefer a concise yet accurate description of the various affections of the skin.

TRANSACTIONS OF THE MEDICAL SOCIETY OF PENNSYLVANIA.—Vol. XVI., 1884.

Here we have a large octavo of over 600 pages, recording the transactions of the above society for

its thirty-fifth annual session, held in Philadelphia on the 14th, 15th, and 16th of May 1884. Many of the papers contained in the volume are of a very high order of merit, and reflect much honor on the medical profession of the old Quaker State. It is not without deep mortification that the Canadian reader is forced to admit the fact of the long rear distance at which our societies stand, in comparison with those of our republican confrères. What is it that we lack? It is not brains; it is not sound initial instruction; it is not individual self-esteem; nor is it overweening modesty. Unity of sentiment and genuine love of country are most probably our greatest defects.

THE INTERNATIONAL ENCYCLOPEDIA OF SURGERY.—A Systematic Treatise on the theory and practice of Surgery, by authors of various nations. Edited by John Ashhurst, Jr., M.D., in six volumes, vol. v. New York: Wm. Wood & Co.

The fifth volume of this admirable work on surgery embraces surgical affections of the head, eye, ear, nose, face, mouth, palate, tongue, jaws, teeth, neck, air passages, chest, breast, abdomen, and hernia. The present volume is quite equal to any of its predecessors, and fully sustains the encomiums already bestowed upon the previous volumes. Those who have not already done so, should immediately subscribe for this magnificent work on surgery.

THE ELEMENTS OF PATHOLOGY.—By Edward Rindfleisch M.D., translated by W. A. Mercur M.D. Blackiston and Son: Philadelphia.

It is a great boon to those who have not time to read all through large books, to fall in with one containing much good matter. Rindfleisch's "Elements of Pathology" is verily one of this sort, a real *multum in parvo*. Every page abounds with valuable instruction, which will not fail to repay the attentive reader for the time he may devote to its perusal.

Births, Marriages and Deaths.

On the 9th ult. H. L. Kent, M.D., of Wallace, N.S., aged 54 years.

On the 7th ult., L. G. Turgeon, M.D., of Montreal, aged 48 years.

On the 18th ult., Dr. Henry Hanson of London, aged 61 years.

On the 20th ult. George E. Richardson, M.D., of Chatham, Ont., aged 45 years.

On the 20th Nov., 1884, W. M. Brett, M.D., of Arkona, Ont., aged 30 years.

THE CANADA LANCET

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,
CRITICISM AND NEWS.

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Original Communications.

UTERINE TUMORS.

A. B. ATHERTON, M.D., L.R.C.P. & S. ED., TORONTO.

(Formerly of Fredericton, N. B.)

CASE I.—Mrs. S.—æt 40, multipara, widow, last child 10 years of age. The patient was sent to me Sept. 29th, 1875, by Dr. White, of Hartland, N.B. She had been always strong and healthy till three or four years ago, when she began to have an increased flow at the menstrual periods, and at the same time noticed a hard lump somewhat to the right of the lower abdomen. A year ago she suffered severe pain in the abdomen and back during two or three catamenial epochs accompanied with much flooding. Since then the quantity of blood lost has been gradually growing less, while there has been a constant watery and mucous discharge. For about two years micturition has been frequent, though the urine was natural-looking and the bowels had to be kept very loose in order to have any passage.

Present condition.—Fairly well nourished. P. 100 and rather feeble. She complained of an unusual amount of pain since her arrival in Fredericton, probably due to her journey in the cars. On examination a large, smooth, semi-elastic tumor was found completely filling the pelvis, its lower end being exposed to view on the separation of the labia. Its surface was found united in places with the vagina, but the adhesions could be readily separated with the finger. A firm hard mass was felt through the abdominal walls, occupying the hypogastric region and reaching fully up to the umbilicus. As the menses had ceased about a week before and the patient was anxious to have an operation at once I decided to accede to her wishes.

Sept. 30th. Operation.—Chloroform was adminis-

tered; assisted by Dr. Coulthard. As it was impossible to get fairly at the neck of the tumor on account of want of room for the hand, I first sliced off perhaps one-fifth of the thickness of the tumor longitudinally. I then could feel its base apparently attached to the left anterior part of the cervix, and being about three or four inches in diameter. Then by means of traction with very large toothed forceps, and the use of a curved blunt bistoury set in a long handle, about two pounds of the mass were removed, leaving rather more of a stump than I could have wished. The patient however became considerably collapsed, though the loss of blood was not so very great, and I was obliged to desist from further efforts. About two hours were occupied in operating. The abdomen seemed to have flattened down completely during the operation, so that little or nothing could be felt there. The vagina was plugged with cotton wool, and $\frac{3}{4}$ gr. morphine administered as a suppository.

Oct. 1.—Rested fairly well; vomited a good good deal; passed water once; P. 112; some offensive discharge; cotton wool tampon removed. There has been very little hemorrhage. Vagina to be syringed with warm carbolyzed water every three or four hours, 3 j. ad. Oj.

Oct. 2.—Vomiting continues troublesome. Not much pain. P. 108. Discharge very fetid. Injections to be continued frequently.

Oct. 3.—Doing well. P. 100; discharge as before.

Oct. 4.—Ate potato yesterday, and bowels are a little loose to-day. P. 108. Quinine mixture ordered, also careful dieting.

Oct. 5.—Bowels better. P. 104. Three bits of sloughy tissue came away yesterday. Discharge still offensive.

Oct. 7.—Discharge less foul for last two days.

Oct. 11.—Discharge is lessening. P. 100. Patient sat up three hours to-day.

Oct. 18.—Discharge very slight. Patient sits up all day now, but looks rather pale and weak. Iron added to quinine.

Oct. 26.—Has been out of doors several times. Wishes to return home and may do so.

On examination I found the entrance to the cervical canal close to the right and posterior side of the upper vagina. The stump of the tumor filled up a good part of the latter and was adherent to

it in places. These adhesions were easily broken down with the finger. Directions were given to get Dr. White to separate any such that might re-form, a few days after getting home.

My patient was so much improved by the operation, that two or three years afterwards she ventured once more upon the sea of matrimony and became Mrs. D. She got along very comfortably until about a year ago, when she began to suffer from a nasty filthy discharge, accompanied by the feeling of something in the vagina. She has also had some irritability of the bladder. Her general condition however has been good. On examination I found a tumor filling the upper three fourths of the vagina, and attached broadly and firmly to the latter at its posterior and lateral surfaces. I could not well get at the attachment to the cervix uteri on account of the size of the tumor and its extensive adhesions. The fundus of the uterus could be felt through the abdominal walls in the right hypogastric region, reaching nearly to the umbilicus.

April 12th, 1883. Operation.—Chloroform was administered, assisted by Dr. Coburn, of Fredericton. I first cut a slice from one side of tumor as before, in order to reach its uterine attachment, which I now found to be only about $1\frac{1}{4}$ inches in diameter. This was first severed, then by dint of traction with forceps, cutting with scissors and knife, previously described, and tearing away with the fingers, the whole mass was slowly detached from the walls of the vagina and removed.

Great care was needed during this procedure to avoid penetration of the thinned recto-vaginal septum. The operation lasted about three hours, and I was ably assisted by Dr. Coburn in its successful accomplishment. Although the loss of blood was comparatively slight, yet the patient suffered considerably from the shock, as after the first operation. Her general condition, however, was better on this occasion previous to operating, and she rallied in a short time. The vagina was tamponed lightly with some pledgets of salicylic silk wrapped in carbolized gauze. The amount of tumor removed was about equal in size to a foetal head at full term.

April 13.—9 a.m. Doing well, had $\frac{1}{4}$ gr. of morphine last night. Some vomiting, P. 76, T. 99°. Tampon removed. Vagina to be washed out three or four times a day with warm carbolized water.

April 14.—P. and T. as yesterday.

April 15.—Less discharge since operation than before. Some looseness of bowels, attributed to her taking some beef-tea yesterday. She states that she is always easily upset by changes of diet. P. 88, T. 99.5°. Purgative in drachm doses pro re nata for the diarrhoea. Also to have dry farinaceous food.

April 16.—Bowels better. P. 84, T. 98.8°.

April 19.—Discharge is very slight. P. 80, T. 98.8°. May sit up a little, and can have a boiled egg and a potato every day.

April 24.—Catamenia came on to-day, being the regular period for them. P. and T. normal. Sits up several hours every day.

April 29.—Has been going about the house for two days. Menses have ceased. On examination the cervix felt large and expanded, the whole uterus also seemed heavier than normal. No trace of tumor found anywhere, unless it might be two or three small hard prominences at the upper and posterior part of the vagina, of the size of split marbles. Some purulent matter was also found in the vagina. The carbolic injections to be continued two or three times daily. Asks to go home to her family. May do so tomorrow. December, 1884, I received a note from the patient stating that she seemed perfectly well and entirely rid of the old trouble.

CASE II.—May 29, 1880. Mrs. H. æt 39, multipara. The youngest child is six years old. Generally healthy till eighteen months ago, when she began to have menorrhagia, and the intervals between her periods became shorter than usual. During the last six months a colored discharge has been present about half the time.

Present condition. Countenance pale, rather thin in flesh, complains a good deal of back-ache, pulse weak. On examination, a small, firm polypus was felt in the cervical canal, about the size of a large hazel-nut. The uterine cavity measured $3\frac{1}{2}$ inches.

Operation. Chloroform was given because the patient was very nervous. The polypus was removed by the scissors, and a piece of cotton wool wet with carbolic acid and glycerine passed into the cervix, and one or two dry pledgets applied over it.

May 30.—Cotton wool removed. Warm carbolized injections to be used three or four times a day.

June 21.—Patient did perfectly well for a week

or two after the operation, but for a week past she has had pains in the back, accompanied with menorrhagia. On examination, a rather soft, solid mass was felt pressing down into the upper cervical canal anteriorly, which at first thought I suspected might be the somewhat inverted wall of the uterus. The sound however could be passed $2\frac{1}{2}$ inches beyond its lower border of union with the body of the uterus, and I therefore decided that it was a tumor in the wall of the latter.

Operation. Chloroform was administered assisted by nurse. The presenting surface of the mass was seized with a vulsellum forceps, and with the help of blunt scissors and fingers, the tumor was gradually enucleated. It proved to be about the size of a small orange. The free surface measured about $1\frac{1}{2}$ inches across, the remainder of the tumor of course having been embedded in the anterior uterine wall. Very little hemorrhage attended the operation. Pledgets of cotton wool were applied as before.

June 22.—Cotton wool removed, carbolized injections to be used three or four times a day. Little or no disturbance from operation, pulse and temp. being as they were previously.

June 25.—Doing well, very little color in discharge and she suffers no pain.

June 30.—Was up about the room two days ago without leave, and since then there has been some bloody flow.

July 2.—Discharge has ceased, the patient is up and dressed.

July 17.—Has continued free from discharge, and left for the country to-day.

THE MANAGEMENT OF PNEUMONIA.

BY M. C. ATKINSON, M.D., BRISTOL, N. B.

Perhaps there is no disease about the treatment of which physicians differ more than pneumonia. There have been, and there still are, two general modes of treating this disease. The first, the antiphlogistic treatment: the second, the expectant plan. By the first it is hoped to cut short the course of the disease or stay its progress. To this end tartar emetic, aconite, and veratrum viride are administered and venesection performed. By the second plan we hope by careful watching, by restraining the violence of the fever—by good

nursing, dieting, and a careful attention to hygienic conditions, to guide the patient through the crisis back to health. In order to reach the subject in a practical way I shall narrate briefly the history and treatment of three cases, and conclude with a few remarks upon the same.

CASE I.—February 6, '84, I was called to see J. H., aged 30, a strong, full-blooded, vigorous man; found him suffering from pleuro-pneumonia. The day previous he was attacked with chills, violent headache, and sharp stitch-like pain in the side. Pulse 120, temp. 105° , resp. 36. The middle and lower lobes of the right lung were consolidated. Gave minim doses of tr. aconite rad every two hours combined with three grain doses of quinine; pulv. Doveri., grs. viii, to be given occasionally to relieve pain. Applied mustard over the whole of the right lung, to be followed by hot wheat-bran poultices, changed every two hours; bled to $\frac{3}{4}$ xx. Saw patient three hours after bleeding; resp. 32, temp. $104\frac{1}{2}$, pulse 112, very soft and full. Expectoration, which has been profuse and "rusty," almost stopped; cough much less severe; delirium and subsultus developed.

7th, Patient much more delirious; mouth dry and parched; pulse 133, temp. 103, resp. 32. Stopped aconite and ordered tr. digitalis and am. carb., continuing quin. sulph., grs. iii, every four hours; also to have six ounces of brandy in milk daily. For four days and nights the delirium continued; chloral hydrate and bromide of potassium, single and combined, within the limits of safety, failing to produce sleep till the fifth night after the bleeding, when he fell into a slumber so profound that he had to be awakened by his attendants. On the fourth day after the bleeding the consolidation had almost disappeared. Acute pain from pleuritic adhesions came on, which was relieved by strapping the chest with adhesive plaster. Under the digitalis the pulse fell from 133 to 112 on the second day after the bleeding, and on the third had fallen to 100. The patient was much exhausted on recovering from the delirium. The pulse remained at 100; tongue brown, dry and parched. He also suffered from moderate diarrhoea, which I did not think proper to check. As the delirium went on I increased the daily amount of brandy to eight ounces; also gave him all the milk he could be made to take. The recovery was very tedious.

CASE II.—On the same day that I made my

first visit to Case I, I was called to see a niece of his, a young woman aged 19, of robust habit. I found her suffering from the same disease, having also been attacked the day previous. Her pneumonia was but slightly complicated with pleurisy. There was extensive consolidation of the right lung, extending from the lower portion of the upper throughout the middle and lower lobes of the right lung. Sputa "rusty" and tenacious, tongue dry and brown, hectic flush on each cheek; resp. 44, pulse 130, temp. 104 $\frac{3}{8}$. I also found congestion of the lower lobe of left lung posteriorly. The same treatment with reference to mustard and poulticing was pursued here as in the preceding case. I also gave the patient two grain doses of quinine every two hours, and am. carb., and tr. digitalis, in ten grain and ten minim doses respectively, every four hours.

February 7. Again saw patient; pulse 135, temp. 103, resp. 48. Crepitation over the upper lobe of the right lung becoming coarser; fine crepitation over a small portion of the left base posteriorly. Ordered four ounces of brandy in milk daily; digitalis and am. carb. to be continued.

8th. Pulse 144, temp. 102 $\frac{1}{2}$, resp. 52. Taking a good deal of nourishment. Ordered all the brandy that she could take. Continued the am. carb. and digitalis; ordered frequent sinapisms to the whole chest. The pneumonia of the left base, luckily for the patient, did not extend.

10th. Patient remained in much the same condition, and I regretted that I had not used the lancet. I did not see her again till the 12th, when I found that a great change had taken place. Incredible, as it may appear, the pulse was 63 and occasionally intermitted, temp. 101, resp. 24; tongue beginning to clean. I immediately stopped the digitalis, am. carb. and brandy; kept up the quinine, and ordered free nourishing liquid diet. The patient made a very rapid recovery, and was able to attend her ordinary work a fortnight before her uncle got out of bed.

CASE III.—*F.b.* 27. Was called to see a man, aged 27 years. He was a large, full-blooded, powerful man, weighing over 200 pounds, somewhat addicted to drinking. He had been attacked that day with severe pain in the right side, embarrassed and painful breathing; pulse 112, temp. 102; some diminished resonance on affected side and tubular breathing, but no crepitation; an

occasional cough, but no expectoration. Gave a saline purge and bled fully twenty ounces; gave tr. aconite rad., \mathfrak{m} iv., every four hours; ordered mustard and poultices to side alternately.

March 1st. Again saw patient. Crepitation now distinct over the anterior portions of the right lung, middle and lower lobes; abundant rusty sputa; pain in side somewhat easier; pulse 100, temp. 102 $\frac{1}{2}$.

3rd. Patient in much the same condition. Pulse, however, running up to 115, temp. 102, respiration laboured.

4th. Pulse and temperature the same, respiration very laboured. Marked nervous prostration, delirium and stupor; cannot answer intelligibly. Discontinued aconite; ordered ara. carb., vin ipecac and quinine, also six ounces of brandy daily.

5th. Pulse 95, temp. 100, respiration less laboured; patient more rational.

9th. Very great improvement in every way; still very weak.

13th. Convalescing. The patient recovered very slowly, the lung remaining consolidated for a long time.

So much for the history of these three cases. Now, I think the point upon which we differ most is the question of venesection. This question has been discussed, and is still being discussed, by some of the best men in the profession, and they differ very much in opinion. Now, what mainly are our objects in bleeding in pneumonia? To prevent death from suffocation; to unload the right side of the heart. Is it a common thing for death to occur in pneumonia from suffocation? For my own part, I have never seen death from this cause, and have read of very few, and I believe that the experience of the profession generally coincides very nearly with mine. But some claim that bleeding favours absorption? This is easily affirmed, but difficult to prove. In case first absorption occurred very rapidly. In my third very slowly. Both were good subjects for bleeding; in both I employed venesection. In case second, a good subject for bleeding, I withheld the lancet; but absorption occurred here also with extreme rapidity. Now, I have treated a large number of cases of pneumonia in the last two years, in two only have I employed venesection, and, of all my cases, these were the most prolonged and

tedious, and in these the nervous phenomena occurred in a manner most marked, when contrasted with those cases which I had treated upon general principles. Now, it is also said of bleeding that it cuts short the disease if employed in the congestive stage. To this I can say, it may sometimes; it does not always. In case third I employed it in the congestive stage, with the result narrated. The pneumonia went on. Still in the case of a strong, full-blooded young man, seen early, and having marked dyspnœa, with the blueness of the face and a turgid condition of the venous system; with a small pulse and laboured action of the heart, showing that the right ventricle was distended and, in the left, scarcely any blood upon which to contract, I cannot but think that the lancet should be used. But how much blood will you take? Some say eight, some say ten, some twenty, some thirty, thirty-five or forty ounces of blood at once. I consider this a point of the greatest importance. I believe that in pneumonia an exception must be made to the general rules laid down with reference to blood-letting.

The average amount of blood in an ordinary man is eighteen pounds; in a full-blooded man of good size we might approximate the amount at twenty pounds. In an extensive pneumonia of one lung you will have four or five pounds of blood, or of material from the blood, thrown out as exudation; in double pneumonia nearly double that amount, viz., eight or ten pounds, leaving in a full-blooded man fifteen or sixteen in single, and ten or twelve pounds in double pneumonia. Now, this fifteen or sixteen pounds of blood in a single pneumonia is not only very much less than what is necessary to carry on the work of the economy, but it is also much deteriorated by the products of inflammation on the one hand, and by defective aeration on the other. Now, what must be the result if you take one and a-half, two, or two and a-half pounds of blood from the veins of a man when it has already been so fearfully drawn upon? The brain, we are told, requires one-seventh of the blood, viz., something over two and a-half pounds. Taking the amount in exudation and making a little calculation, you will find that you have a reduced blood supply to the brain of nearly one-half. Now, you will find, if you do this, the nervous symptoms, which may have been

mild before the bleeding, will become pronounced in a short time after the bleeding. Take a man in full health and bleed him to the extent of seven pounds—few of us would care to do it—and yet that man is able to reproduce the lost blood in a short time, because his powers of assimilation and absorption are unimpaired; but the man who suffers from pneumonia is in no such condition, the whole system is profoundly disturbed, and the blood-producing powers almost at zero; and yet there are some who would not hesitate to take two or two and a-half pounds of blood. Now, if this is a strong case in single pneumonia, what must it be in double pneumonia?

Here you have eight or ten pounds of exudation taken from the blood, ten or twelve pounds left in the body—say you have twelve pounds left in the body. You take away two more; you have ten left—just half the blood, and loaded with the products of inflammation and very improperly aerated. It does appear to me that a physician should be sure of his case before he would adopt such heroic measures. Bad as is the mortality of double pneumonia under the cautious, conservative, and I believe, judicious treatment of late years, I am persuaded that it would be woefully increased by such a measure. Even in the case which I have drawn as being one in which it would be appropriate to use the lancet, the quantity taken should not be large: not above eight or ten ounces, or, at the outside, twelve ounces. In the cases in which I adopted it I believe I withdrew too much. I am led to this conclusion by the very marked nervous prostration and tedious convalescence which followed the measure. Another point: When should you bleed in pneumonia? In the congestive stage. It is then that the right side of the heart is loaded; it is then, if at all, that you may hope to cut short the disease; it is then that you may hope to lessen its severity. If you wait till exudation is completed and then bleed, you only further debilitate a patient already sufficiently debilitated, and narrow his chances of recovery.

AN ADDRESS READ BEFORE TRINITY COLLEGE MEDICAL SOCIETY.

BY G. A. BINGHAM, M.D., TORONTO.

Demonstrator of Anatomy.

MR. PRESIDENT,—When informed that your committee had honored me by appointing me to

read a paper before you to-night I was at first puzzled, and then a feeling of actual helplessness began to overcome me as I took in the full force of the situation. In order to read a paper one must have a subject. The subject upon an occasion such as this should be fresh and entertaining, for if I understand properly the object of these reunions—these open meetings of your society, we are not here to listen to the dull technicalities of science or philosophy, nor to have exhibited to us the awful niceties of the surgeon's blade, nor to endure panegyrics upon the virtues of *Gossypium* or *Jaborandi*. All these delicacies are, no doubt, done full justice to at your regular meetings. But upon occasions such as the present, whether as friends, medical students, or practitioners, we are for a time to throw aside the cares of everyday life, and banish from our minds all thought of the morrow's burdens, and while this hall resounds with the inspiring strains of old "*Litoria*," the physician is to fancy himself once more, as in "*Auld Lang Syne*," sacrilegiously carving his name in undying letters upon the furniture of his alma mater. And those friends who have honored us by their presence to-night are to wish that they, too, had been medical students. No wonder, then, that I was puzzled to select a subject suitable for such an occasion. In my despair I appealed to your worthy President, and he blandly suggested that in my paper I should attempt a solution of the conundrum of the nineteenth century. Fellow students you will perceive at once the inappropriateness of such a subject, for, while we all concur in the determination never to give up that conundrum, we are all equally agreed that its solution, like many other grand mysterious dispensations of Providence, is completely beyond our powers. Thus thrown upon my resources I thought of writing an essay on "*How to prevent the cholera invasion*," but, as my remarks would probably never have been even heard of by the International Convention, fortunately for you I abandoned that idea. Then the idea of writing up the trials of medical students suggested itself to me. The medical student! The professor's pride and the policeman's pet—that anomalous being so little understood by those among whom he lives,—accused of all the misdeeds in the calendar of crime,—persecuted, frowned upon and laughed at by those who may some day invoke the aid of his

skill to rescue them from an untimely grave (and it is needless for me to state that assistance will be magnanimously, I may say even cheerfully, extended at the maximum rate of two dollars per bottle). And yet, Mr. President, anyone who is thoroughly acquainted with the actual condition of affairs must acknowledge that we have no class of students who labor more assiduously to prepare themselves for future usefulness;—none who so honestly strive to master the details of that mighty principle which underlies the alleviation of human misery; and none, when occasion calls, who so willingly brave contagious disease and death for the benefit of their fellow-beings. Speaking of medical students one is naturally brought to the consideration of a subject which, did time and your kind patience permit, I should have liked more particularly to dwell upon—I mean the preparation of the medical student for his life work, and what share literary education should have therein." I have no doubt many will exclaim, "The science of medicine is of itself sufficiently extensive to occupy our whole attention." I thoroughly agree with you, my friend. My recollections are too painfully vivid for me to forget the midnight toil and the early hours of the medical student. I cannot yet obliterate from my memory the total absorption of one's mental faculties in the mighty volume of "*Gray's Anatomy*," until one's very hair threatened to partake of the nature of the subject and turn—*Grey*.

Nor do I forget the painful delvings for grains of diagnostic truth in the stony bosom of "*Flint*,"—and the steadily increasing burden of work as the session approached its close, until one had not even time for those devotions at the shrines of Bacchus and of Venus, which some well-meaning but misinformed people consider so essential to every properly constituted medical student.

Notwithstanding these facts I cannot but believe that, if the preliminary education of a medical student possessed more of a literary character, it would not only enhance his future usefulness, but would increase his facilities for attaining to prominence in the pursuit of his medical course.

We have, to-day, medical men occupying some very high positions in this country of ours. The legislative halls of Canada contain many representatives of our profession. We are all proud to know that a former graduate of our beloved Alma Mater now occupies a position in the cabinet of

Manitoba ; and another member of our profession is our representative in England as High Commissioner (some call him our *very* High Commissioner, whatever that may mean). In view of the fact, then, that our fellow-countrymen have been pleased from time to time to select from our midst men to represent them in the councils of the nation, it behoves us all so to prepare ourselves that, should it ever be our lot to be so chosen, we should do honor, not only to our country, but to our profession.

But in what way would literary training be of *direct* advantage to a student of medicine ? While the study of classics, ancient or modern, or the acquiring of the romance languages, or the research after great mathematical truths, may not have any direct bearing upon the study of medicine, yet who will deny their influence in strengthening the mind and expanding the intellect ? Who will deny that he whose intellect has been cultured and strengthened by familiar intercourse with the philosophers, the moralists, the statesmen, the historians, or the poets, of ancient or modern days, is better fitted to pursue the researches into the mysteries of growth and decline, of health and disease, of life and death ?

Undoubtedly a liberal literary education will inculcate habits of study, discrimination and discernment, all invaluable accessories to the student of medicine ; and he will indeed be a public benefactor, a servant who has nobly served his country, who will, by some means at present unknown, reconcile the laborious life of a medical student with the attainment of literary knowledge ; and he will certainly deserve to have engraved upon his tombstone the epitaph, suggested, I believe, by Mark Twain for his poor old servant, who, in a state of inebriation, fell upon the red-hot stove and, before being rescued, was burned to a crisp : " Well done, good and faithful servant."

In conclusion, gentlemen, I would say : Make the science of medicine your first love, and lovingly array her in the mantle of literary excellence, bedeck her with the gems of culture, adorn her with the priceless diamonds wrested from the bosom of literature ; and then, and not until then, will you have done justice to your heart's first love, your chosen science ; and then, and not until then, will that science stand forth flashing with the peer-

less rubies of truth, and, exalted upon a pedestal far above the petty tyranny of prejudice, will receive as homage, the appreciation and admiration of all men.

Correspondence.

TO THE MEDICAL ELECTORS OF KING'S AND QUEEN'S DIVISION.

GENTLEMEN,—Ten years have now elapsed since I addressed you as a candidate for this division,—since which time I have closely attended to your interests as your representative in the Medical Council. Whether I have succeeded in fulfilling these duties—my record is before you ; you are the judges.

I have again been solicited by a highly respectable number of my professional brethren to offer myself as a candidate for your suffrage in 1885. It is very gratifying to me to have such a respectable number of my friends come forward, many of whom unsolicited have appended their signatures to my nomination paper. Some time ago I had every intention of retiring from the responsibilities of office, but was so strongly urged once more to enter the arena I could not do otherwise than allow my name to be used for that purpose. Many of you have certainly given me more credit than I deserved for alleged zeal in your behalf. Allow me to state that I have always been devotedly attached to the medical profession—not so much for the emoluments as for the scope which it offers for mental gratification in the cause of suffering humanity, although we sometimes receive the doubtful honor of unmerited abuse from many of those whom we often risk our own lives to serve without any reward whatever. However, we have hours of happiness in the thought of doing more real good to mankind than all the other professions put together. It is altogether unnecessary for me to say much on the duties devolving on the members of the Council. I might say, however, that it is in contemplation to have the Medical Act amended. Some of those amendments I approve of, others seem to me of rather doubtful propriety—such as the increase in our annual assessment. I have not yet seen a medical man in this division who approves of such a step. The law also ought to be amended whereby actions for

malpractice shall be brought within a limited time and security given by the plaintiff for costs incurred in the bringing of such suit. In the majority of cases tried the plaintiff is some miserable creature, with scarcely the coat on his back or even the will to earn it. To say nothing of the trouble and anxiety, the loss to the defendant is very great whether he is successful or not; not unfrequently ruin is entailed and probably his prospects blasted for life. There are other improvements that might be stated, the nature of which I shall not enter upon; but if you should feel at liberty to tender me your vote it shall be my pleasing duty to do everything in my power to promote the honor and dignity of the profession generally.

Thanking you for the confidence you have so long reposed in me, I have the honor to be, gentlemen,

Yours sincerely,

W. ALLISON.

BOWMANVILLE, 9th March, 1885.

Reports of Societies.

ONTARIO BOARD OF HEALTH.

The regular quarterly meeting of the Ontario Board of Health was held in Toronto on the 12th ult.; present: Drs. Covert (Chairman), Cassidy, Rae, Yeomans, Oldright, and Bryce, the Secretary. The Secretary read a communication from Mr. Crown, of Sault St. Marie, relating to the proximity of the burying ground to the dwelling houses. A communication from Dr. Harris, Medical Health Officer of Brantford, asked if the municipal authorities in Ontario had power to regulate the cutting of ice. Dr. Bryce stated there was no provision in the Municipal Act regulating the cutting of ice, but he understood that Mr. Badgerow was going to submit a resolution to the Local Legislature making provision for the same. The question of preventing the existence of cemeteries within a certain distance of dwelling houses was also to be considered by the Legislature. The Secretary made his quarterly statement of the work done in connection with the smallpox outbreak in Hungerford township. When the Provincial Health Board authorities had entered the affected district the spread of the disease was most effectually stopped. The desirability of establishing a vaccine farm in connection with the Experimental Farm, at Guelph,

was discussed and a committee appointed to confer with the government in relation to the matter. The Board adopted the following memorial to the Dominion Government on quarantine regulations: That in view of the probable introduction of cholera into this continent, and of the fact that smallpox has been introduced into the province by immigrants several times during the past year, the Board would respectfully submit the following additions to the regulations already in force for preventing the introduction of contagious diseases:

1. Clean bills of health to be issued by the District Medical officers to emigrants purposing to embark at a foreign seaport.

2. Appeal to the Government at home for arrangements whereby the quarantine officers at the various seaports of our Dominion might by cablegram be advised of the departure of vessels from English ports having on board emigrants from infected countries. Provisions also at ports of departure for suitable buildings in which intending emigrants on whom infectious diseases have developed may be cared for until convalescent.

3. Precautions to be observed on board ships carrying emigrants during a time of prevalence of cholera or smallpox. In proportion to number of emigrants carried, space to be set apart in a suitable portion of the ship for an isolation hospital with greater provision for free ventilation.

4. During the prevalence of cholera the premonitory diarrhoea should be carefully attended to; excreta received in vessels containing one pint of a solution of mercuric chloride and permanganate of potash, of the strength of two drachms of each to a gallon of water; body and bed linen, if soiled, to be destroyed, or immediately placed in soak and boiled in same solution.

5. Quarantine stations to be supplied with boarding stations, consisting of suitable wharves and boats for (1) boarding vessels and for transportation of the sick; (2) places of sequestration for those that are well, but have been exposed to the disease during the passage and have not yet passed the period of incubation.

- 6 Hospitals for the sick with various infectious diseases, to be placed at distances apart, to prevent the germs of one disease being transmitted to another.

7. Vessels on arrival should have the following points established:—(1) Sanitary condition of port

of departure; (2) Sanitary condition at time of leaving; (3) History during passage; (4) Sanitary condition on arrival, with reference to cleanliness of quarters of steerage passengers and crew.

BRANT COUNTY MEDICAL ASSOCIATION.

The usual quarterly meeting of the Brant County Medical Association was held in Brantford, on the 3rd ult. There were present Dr. Marquis, Mt. Pleasant, President; Drs. Philip, Henwood, Griffin, Digby, Winskell, Secord, Branford; Dr. Kitchen, St. George; Dr. Fairchild, Mt. Vernon; and Dr. Davidson, Langford.

It was moved by Dr. Digby, seconded by Dr. Philip, That a resolution which was adopted at a former meeting of this Association in reference to contract practice be rescinded.—*Carried.*

Dr. Philip exhibited a tumor (steatoma) of large size and many years growth which he had recently removed from the shoulder joint. The wound had healed by first intention.

Drs. Digby and Kitchen were appointed to read papers at the next meeting of the Association.

After some routine business had been disposed of the Association adjourned until the first Tuesday in June.

Selected Articles.

OVARIAN TUMOR IN A YOUNG GIRL.

Clinic by Prof. Thomas, New York.

Our first patient to-day is Margaret H—, born in Nova Scotia, aged eighteen and single. The history which she gives of herself is a very striking one in many respects. She says she has been sick for two years, and that up to two years ago she was perfectly healthy. At that time she had a very hard fall, striking flat on the abdomen, and the next day there came on a very severe uterine hemorrhage. This flowing continued for several months—three at the least—and she says she then called in a physician, who gave her some medicine which gradually stopped it. Since then, however, there has never been any return of the menses; but, as time went on, she noticed that her abdomen was gradually growing larger. She is now as large as a woman ordinarily is at the eighth month of utero-gestation, and she says there has been no menstrual discharge for at least eleven months.

The abdomen of this young girl presents, then, a large hard mass, and she comes here to-day to find

out what the trouble is. Suppose that, instead of coming to the college, she had gone to the private office of any one of you. You can see at once that very delicate questions would have arisen for you to decide, and that a great deal would have depended on the diagnosis which you made; for the case is one of importance in many ways. In the first place, she might have slipped on a sidewalk of a city like this, and, attributing all her trouble to the fall, might have called upon you for an opinion which would justify her in bringing suit for damages against the municipal authorities for the condition of the streets. Thus, next week I shall have to make an examination in the case of a woman who slipped and fell three years ago, and who ever since has suffered so greatly from dyspareunia, that marital life is a serious burden to her. In consequence of this she is bringing suit for \$12,000 against the city, and I shall have to be extremely careful in expressing an opinion as to whether or not the trouble of which she complains is really attributable to the injury incurred in the fall.

Another important point to decide here is, what sort of an abdominal tumor is this, and what connection has the amenorrhœa with it? Perhaps the amenorrhœa may be natural, and the tumor a living one. As to the statement of the patient that it has continued for eleven months, that should have no weight whatever in affecting our opinion of the case. Many instances have, unfortunately, occurred in which the abdomen has been opened and the trocar plunged into a tumor supposed to be ovarian, which proved, to the operator's chagrin, to be nothing more or less than a gravid uterus. If utero-gestation should really exist, and you should express the opinion that this was not the case, or if just the opposite of this should be true, you can readily see in what an unpleasant position you might place yourself. Let me show you, then, how I would advise you to conduct your investigation in a case like this, in such a way as to avoid error and arrive at the truth. The problem you have to solve is, what is the character of this tumor, and what its connection with the uterine hemorrhage and the subsequent amenorrhœa?

What, now, might it be? It might possibly be any one of thirty or forty different things; but the most of these conditions are so exceedingly rare as to render it unnecessary to take them into account at all. What, then, are the things it is really likely to be? First of all, in every such case you should always, without any exception whatever, think of utero-gestation. Even if it were one of the vestal virgins themselves, let this be the first supposition on which you proceed with your examination.

At the period of pregnancy, when the abdomen is as large as in the present instance, the cervix ought to be quite soft and a little patulous, and the markedly protuberant anterior wall of the uterus

bulging in front of it ; while through the os something hard (whether the head or the back of the child) should be felt moving up and down. Instead of this state of affairs, I found on examination here the cervix and uterus of a virgin, and venturing, on account of this, to pass the probe, it entered the cavity, which I ascertained to be empty for two and a-half inches, and in a direction which showed the uterus to be turned backwards. But, notwithstanding all this, the patient might still be pregnant ; for this might possibly be one of those rare cases where there is a double uterus. I began therefore, my examination on the outside of the abdomen. If in a case of pregnancy you keep your hands steadily upon the uterine tumor for some time, you cannot fail to detect a hard mass and the movements of the child. Then, with careful auscultation you ought to be able to distinguish the foetal heart-sounds, the so-called placental *bruit*. The latter is in reality a uterine *bruit*, however, as the sound is caused by the rushing of the blood through the uterine sinuses. Nothing of the kind was found in this case ; nor were there any mammary indications, or any other sign of utero-gestation whatever. This hypothesis is, therefore, to be discarded.

Secondly, the abdominal enlargement might be caused by a uterine fibroid ; but in that case the tumor would be very hard and unyielding. Here, on the contrary, I can get a distinct wave on palpation. Has the patient, then, ascites, which might perhaps too be due to disease of the liver, or of the peritoneum ? If this were the case, there would be perfect resonance on percussion at the upper part of the tumor, from the fact that the intestines would float on the top of the water. There is, however, not a trace of resonance at the top, the percussion-note being perfectly flat at that point, while there is resonance at the sides, much more marked on one than on the other. She has not, therefore, ascites.

We arrive at the conclusion, then, that she is probably suffering from some form of cyst. This might possibly be of the liver, the kidney, or some other organ ; but there is one kind of cyst that is so vastly more common than any other that we will be hardly likely to err if we conclude it to be of this character, and that is the ovarian. There are special reasons also for supposing it to be an ovarian tumor. The mass extends fully down to the pelvis, and it has pushed the uterus backward and downward, as we have previously ascertained. To show you how valuable I regard the former of these signs, I will mention that in a case in which I operated about six months ago, as soon as I found that there were intestines between the tumor and the iliac fossa, I confidently asserted that whatever else the growth might be, it was certainly not an ovarian cyst. The result proved it to be an enormous cyst of the kidney, its size being one and a-half times as large as my head.

So much for the diagnosis of the tumor : now for the question of its etiology. Let me caution you in the first place to beware how you give your support to the hypothesis (on which a suit for damages may be based) that because a certain difficulty from which a patient is suffering came after a fall or other injury, that it is the result of that injury. Some time ago a lady consulted me who said that she had a severe fall upon the back, and that profuse uterine hemorrhage had immediately followed. From her account, I supposed that it was probably a typical case of acute retroversion of the uterus ; but when I made a vaginal examination, what was my surprise to find that instead of this there was advanced carcinoma of that organ. Yet the patient until that time had never had any hemorrhage or other symptom to indicate the presence of malignant disease. You must be on your guard, therefore, in regard to *post hoc, propter hoc*. I doubt not that the fall was the exciting cause of the hemorrhage here, but do not believe that either the hemorrhage or the amenorrhœa would have resulted if the ovaries had been in a healthy condition at the time of the accident. I am speaking only from experience ; but in the light of that I do not hesitate to say that this girl's trouble is not due to any such cause. On the contrary, I believe that at the time she fell she had cystic degeneration of both ovaries. The fall, however, probably did cause the rupture of one or more of the ovarian cysts, and thus gave rise to the hemorrhage ; while as the hemorrhage continued, the ovary went on increasing in size.

Finally, as to the prognosis. Unless ovariectomy is performed, it is a completely hopeless one. I need not say how fully established is the point that drugs are utterly useless in this affection. You will doubtless hear of many cases of ovarian tumors which have been cured without resort to the knife ; but the explanation of this is that they have not been true ovarian cysts. It not unfrequently happens that a patient comes to an ovariotomist with a tumor of considerable size, but because he thinks it is not at the time sufficiently large to demand removal, he tells her to return to him in six months ; yet when she comes back to him at the end of that time the growth may have entirely disappeared. This is because it was a par-ovarian cyst, a simple cyst of the broad ligament, which contained nothing but pure serum ; and it is the cases of this character in which the recovery takes place spontaneously, though the cure is generally attributed to whatever medicine the patient happens to be dosing herself with at the time.

This being, without doubt, however, a true cyst of the ovary, ovariectomy becomes imperatively necessary. When, then, shall the operation be performed ? At once, I should say. The late Professor Peaslee, one of our highest authorities on the subject, was in favor of postponing the opera-

tion to the last possible moment, on the ground that the patient ought to be permitted to enjoy life as long as she could. But the fact is, that the patient cannot enjoy life with such a tumor. Its presence makes her utterly miserable, and after it has attained a certain size the sooner its removal is accomplished the better; not only because of the inconvenience and suffering which she will be spared, but because her chances of recovery will be much better than if it is postponed too long. The tumor in the present case now, no doubt, weighs twenty-five or thirty pounds, and it is high time that it should be gotten rid of.

I feel almost certain that double ovariectomy will have to be performed here; and for the reason that the patient has not menstruated for eleven months. The fall, certainly, had nothing whatever to do with this, for women are continually meeting with all sorts of accidents and injuries, but they go on menstruating just the same if the ovaries are healthy. It is the cystic degeneration of these organs, and not the fall, which has put a stop to this young woman's menstruating.

CYSTS OF THE UTERO-VAGINAL GLANDS.

Mrs. Ann R—, thirty years old, has been married three years, and has had one child. This is a very acute case compared with most of those that we meet here, as she says she has been sick only eight days. Eight days ago she began to suffer intense pain, accompanied with a burning sensation, whenever she attempted to pass urine, and yesterday she noticed, for the first time, a lump gathering within the vulva. This is the history.

One of the great advantages of a clinic like this is, I think, that many of the cases which you see here are likely to present themselves to your minds when in the future you meet with similar ones in your own practice; and it may be that many years from now the memory of some special case here at the clinic may enable you to successfully treat one of the same character which you then meet with for the first time yourself, and which might have otherwise proved a puzzling one to you. Thus the present case may fix itself in the memory of some of you, just as one that I will now mention did in my own. Twenty years ago a lady from the South consulted me for aggravated dysmenorrhœa; the pain coming on during the first day of the flow and being excruciating. It was before the days of the hypodermic syringe, and her suffering was so agonizing that nothing seemed to give her much relief. After remaining in New York for a number of months without receiving any permanent benefit she returned to her home in the South, where some time afterward her physician removed a small fibrous polypus, hanging by a pedicle from the uterine canal; and after that she had no further trouble. The explanation of the case was, that this little fibroid, being comparatively free in the cavity, had acted like a ball-valve in preventing the

escape of the menstrual blood, and thus set up the uterine contractions which caused the patient such extreme pain. Gradually, the fibroid worked itself downward along the uterine canal, until it was finally extruded from the cervix, when its removal became a very trifling matter.

Since then I have never met with a case in which the symptoms were quite the same as in this case until this very day, when a lady came to my office who suffers in precisely the same manner. Whether the trouble is due to the same cause I do not know; but, with the experience of the other case in mind, I shall at all events take the precaution of dilating the cervical canal with sea-tangle, and examining to see whether there is not such a fibrous polypus present; and it probably would not have occurred to me to do this if I had not come across the other case twenty years ago.

In the case now before you which, perhaps, may recur to some of you many years from now, there is a cyst of considerable size under the right *labium majus*, which is excessively painful to the touch; and under the left arm there is a similar, though smaller, cyst.

So much irritation have these cysts caused that there is now quite a severe vulvitis in consequence. If you did not make a correct diagnosis, this case might give you a good deal of perplexity; but, if you recognize its true character, you would find it one of the most curable cases to be met with in practice. These cysts are due to a degeneration of the vulvo-vaginal glands, whose excretory ducts have been closed by inflammatory action. The vulvo-vaginal glands were first described by Bartholinus, after whom they are often called; but, strangely enough, his description was lost sight of for a long time, and they were rediscovered, as it were, by M. Huguier, of Paris, in 1841. When they become inflamed vulvitis, urethritis, and more or less vaginitis, are the results, as in this case, and coitus becomes utterly intolerable. In this condition all sorts of lotions and soothing applications are oftentimes ordered; but such treatment is absurd, for the reason that the ducts of the glands, as has been mentioned, are closed by the inflammatory action. If we could probe them with the same skill that the oculist does the lachrymal duct, good results might perhaps be secured by the operation; but I have never heard of such a thing being done. The treatment that I unhesitatingly recommend in such cases is to snip off a section of the cyst (having first anæsthetized the patient), and then stuff it with carbolized cotton. This cures permanently, because the gland soon disappears entirely after the operation. The French writers advise dissecting out the gland; but the great objection to this procedure is that a branch of the pudic artery is very likely to be severed in it, and as the artery lies very deep under the ramus of the pubes it is difficult to control the hemorrhage that results.—*Medical and Surgical Reporter.*

GASTRALGIA.

Clinical lecture by Dr. William Pepper, published in the *Medical Times*:

This man a farmer, aged 39 years, has been sick for two years. His principal complaint is of pain in the left side. He has lived in a healthy locality, and has never had chills and fever. The pain begins in the left side and runs back to the left shoulder-blade. If he eats too much he suffers, but the kind of food taken does not appear to influence the pain. An ordinary meal does not make the pain worse, and eating sometimes takes away the bad feelings. Active exercise or riding over a rough road is apt to bring on the pain. The appetite is fair. The bowels are sometimes constipated, but as a rule he has diarrhoea about twice a week, there being two or three loose stools, but these contain no blood. He weighs one hundred and fifty pounds. His best weight was one hundred and sixty-two pounds, but during the summer he goes as low as one hundred and forty pounds.

Let me here refer to this matter of variation in weight. Many persons will be met with who have a wide range of what may be called normal weight. I never like to see this symptom, for it seems to me that those persons who lose flesh so rapidly cannot be made of very good stuff. A person whose flesh is solid and who is living a correct life should maintain pretty nearly the same weight summer and winter, varying perhaps from three to five pounds. Persons will however, be found whose weight varies twelve or fifteen pounds at different periods of the year. With such persons I have observed that sickness goes hard; on the other hand, loss of weight in them is not to be regarded as of such serious moment as it would be in a person who was thoroughly in training and whose flesh was solid and well organized.

In reference to the pain complained of, when this pain is in the right side, we naturally suspect some trouble with the liver—a gall stone in one of the smaller ducts or in the gall-bladder; some congestion in the liver, causing dragging on the suspensory ligament, or irritation of the capsule of the organ. When the pain occurs on the left side, we think of the spleen, the pleura, and the heart, and when, as in this man, the pain associates with some shortness of breathing and overaction of the heart, we are apt to think more particularly of the heart. Examination of the heart shows it to be perfectly normal. There is no enlargement of the organ, no displacement of the apex-beat, and the valvular sounds are free from murmur. Neither is there any evidence of chronic pleurisy. There is good respiratory murmur and resonance over the left side. Examination of the spleen shows that the organ is not enlarged and that the man has not lived in a malarious district.

Before satisfying ourselves that this is merely a

neuralgic trouble (possibly a form of gastralgia), some obscure conditions must be thought of. One of the most insidious of these, and one against which we should be continually on our guard, is caries of the spine. Caries of the anterior surface of the vertebræ constantly reveals itself by pain and distress in the neighborhood of the spinal column. Many cases of sciatica or intercostal neuralgia will be found to be due to caries of the anterior surface of the vertebræ, and the diagnosis should not be made until a sudden increase of the symptoms, with some numbness and failure of power in the lower extremities or the appearance of an angular projection, calls attention to the real cause of the trouble. You will do well to be on your guard against the occurrence of this obscure lesion. Aneurism of the descending aorta is another condition to be excluded.

There is no tenderness along the spine, neither is there any projection of the vertebræ, and jumping does not cause pain. No pulsation, thrill or abnormal dulness can be detected. Caries of the spine and aneurism may therefore be excluded.

You observe that the pain is described as occurring in the right side and over the stomach; it is not markedly affected by eating, although radishes and some other vegetables make it worse, and it is worse when the stomach is empty than after an ordinary meal. It is associated with evidence of derangement of intestinal digestion, as shown by flatulence and irregular action of the bowels, sometimes constipation and sometimes transient attacks of diarrhoea. Having excluded the graver causes for this pain, we must conclude that it is neuralgic and occupies the stomach, and therefore a form of gastralgia.

As to the cause of this; the family history is good, and he has good health until this affection developed. He does not use liquor or tobacco; he has not been overworked, but has gotten into the habit of eating his meals hurriedly. The gastralgia has probably been brought on by this rapid eating.

In the treatment of gastralgia the regulation of the diet is the chief element. The stomach is rarely able to receive and handle enough of food in three meals to support the system; consequently it is important that such patients should take more than three meals in the twenty-four hours.

Again the stomach is so hyperæsthetic and the mucous membrane so irritable that unless some digestible substance is in the stomach the acid juices are apt to excite pain, and hence the pain is more marked when the stomach is empty, and the ingestion of food affords relief; so that for this purpose, also, it is desirable to give food oftener than three times a day. Meals of smaller amount, and of extremely simple character, and at shorter intervals, is the rule for the nourishment of gastralgic patients.

The character of the food requires close very close attention. In general, it will be found that milk is one of the best ways in which to give nitrogenous and albuminoid food. The starchy foods are, as a rule, well borne, particularly as they do not require much gastric digestion, being digested as you know, by the salivary, intestinal and pancreatic fluids. At times, however, the starchy foods lead to the development of secondary acids in the stomach, in which case it becomes necessary to diminish the amount of starch allowed and increase the amount of skim-milk, the patient being practically placed on an exclusive milk diet for a certain length of time. Alkalies are often desirable, and lime-water mixed with milk is a convenient way of administering these.

I shall recommend for this man the following dietary :

Breakfast.—Soft-boiled egg, oatmeal, bread and butter, and milk with lime-water. Between breakfast and dinner, a glass of milk and lime-water.

Dinner.—Potatoes, bread and butter, and milk and lime-water, but no meat. Between dinner and supper, a glass of milk and lime-water.

Supper.—Mush and milk with milk and lime-water to drink.

In selecting the remedies to be associated with this diet, you will be governed by your appreciation of the state of the mucous membrane more than by anything else. If there is no evidence of gastric catarrh, if there is simply the hyperæsthetic neuralgia and anæmic condition of the stomach, iron, arsenic and belladonna may be given at once with confidence, the stomach being sheathed with bismuth taken at proper intervals after eating. Under such circumstances, a pill containing the following might be given : *R.* Quinæ sulph., gr. j. ; acidi arseniosi, gr. $\frac{1}{60}$; pil. ferri carb., gr. j. ; ext. belladonnæ, gr. $\frac{1}{40}$; *M. et ft. pil. no. 1.* Sig.—To be taken after food, three times a day.

Any of the vegetable salts of iron may be substituted for the pill of the carbonate. In addition to this, ten grains of bismuth should be given two hours later to protect the stomach when most empty.

If there be a catarrhal condition of the mucous membrane, as shown by a coated tongue, distress in the stomach, in addition to the paroxysmal pain and evidences of dyspeptic trouble, we are obliged to adapt our remedies to this condition, postponing the use of anti-neuralgic remedies until the inflammation of the mucous membrane is relieved. In such cases bismuth with pepsin, dilute mineral acids, carbolic acid, and salts of silver become exceedingly valuable for their antacid, sedative, and alternative properties.

For this patient, having directed a careful diet with alkali, we shall order minute doses of nitrate of silver with belladonna.

Two weeks later, the patient reported much improved, and the pill of quinine, arsenious acid, and iron above given was substituted for the nitrate of silver, the same diet being continued.

FOREIGN BODY IN THE PHARYNX.

Walter F. Atlee reports the following case in the *Med. Times* :

It is not at all an uncommon occurrence to have a visit from a patient who complains of having swallowed something that is still sticking in the throat. In almost every one of these cases there is no foreign body in the passage. Those patients have a local pain, in some cases the result of injury by a hard body hurriedly swallowed, and they are so entirely convinced by this sensation that a foreign body has lodged there that it is impossible to make them believe otherwise. The surgeon himself may make a mistake, and think he feels a something that ought not to be there. I heard even Nélation say that in a certain case, after pushing his finger deeply into the pharynx, and feeling a small resisting body, he made several attempts to seize it with the forceps before discovering it to be the great horn of the hyoid bone.*

I made observations somewhat similar to these to a man who came, in great excitement, on the evening of the 30th of last December, to take me to consult with a well-known and experienced physician in the northern part of the city in the case of a child in a dying condition from the presence in the throat of a pin, as the father protested, but which the doctor had not found and did not believe to be there. On the afternoon of Christmas-day, five days before, the father said his child, just seventeen months old, most certainly had a pin in her mouth, that it had disappeared when he went to take it out, and the symptoms of throat trouble began at that time. For five days the child had taken food with great difficulty and reluctance, keeping the hands in the mouth as if striving to pull something from the throat.

It will here be called to mind that while more bulky objects generally become arrested at the junction of the pharynx with the œsophagus, where the tube is narrowest and least easily expandible, a thin and pointed body, such as a pin, generally sticks between one of the pillars of the fauces and the tonsil, or thereabouts. Again, when such a body stops in the pharynx, that which takes place is owing less to its size than to its shape: it is a body that, as a rule, cannot be pushed farther instead of being extracted, as is often done with bodies of another kind. *It must always be extracted.*

On reaching the house, the child was found ly-

*See Clinical Lectures on Surgery, by M. Nélation, p. 64.

ing in a cradle, on her left side, the head thrown back, in a state of stupor, from which she could be roused but very imperfectly. She had had during the day several convulsions. The lips were bluish, and the whole countenance extremely pale, with a bluish tinge. There was a swelling in the neck on the right side, which was the uppermost, below the mastoid process, posterior to the line of the ear. This swelling was not so hard as in cases of diphtheria: it had the feel of cellular tissue affected by acute œdema and not by phlegmonous inflammation. In the mouth was some ropy mucus tinged with blood, but there was no repulsive odor. While examining these appearances it was suggested that the child had the mumps. There was no swelling, however, about the temporo-maxillary articulation, nor anywhere anterior to the ear. It was posterior to the ear and inferior to the mastoid process. Moving the head, the left side of the neck presented a condition similar to that on the right, though not so marked.

The attending physician said his treatment had consisted mainly in the administration of the chlorate of potassa in a syrupy solution. He did not believe in their being any foreign body in the child's throat but was very willing to have search again made for it. When searching for it himself, he had made use of his eyesight only, and had never passed his fingers into the pharynx.

The child was taken up and held in the nurse's lap in a convenient position for the examination of the pharynx. The doing of this roused her somewhat, so that a few drops of chloroform were used to quiet her. The mouth was then opened, and the jaws kept apart by a large cork. Then the finger was passed into the throat a pin was encountered, firmly fixed there, and seemingly stuck, one end between the right tonsil and the pillars of the fauces and the other in the posterior wall of the pharynx. The extremity of the forefinger of the left hand being kept in contact with the pin as a guide, a dressing forceps was made use of; and on the second attempt to seize it, and with the use of some force and some manoeuvring to dislodge it, the pin was withdrawn. The pin was exactly an inch and three-sixteenths in length, and it was bent in the centre at an angle of about a hundred and twenty degrees. This bending could scarcely have been produced by the force used in extracting it from the throat.

As there was, of course, great difficulty, even impossibility, in making the movements of deglutition, and every attempt to swallow must excite reflex movements in the pharynx and retard cure, it was advised that no food or medicine should be given by the mouth. In order to try to nourish and stimulate the patient, appropriate enemata were ordered. The child, however, never revived, the stupor became more and more profound, and she died the following day,—just twenty-four

hours after the removal of the pin. The cause of the trouble, the source of the irritation, having been gotten rid of, hopes were entertained that the patient might recover, but, as is often the case in children when the exhaustion and the enfeeblement of the nerve centres have been so great that repeated convulsions are the result, she never again became conscious, and life gradually went out.

The history of this case teaches nothing new, but it is well at times to be reminded of what may occur, and of the extreme care and watchfulness that are at all times demanded in the practice of our profession, in order to avoid sad and even fatal mistakes.

FRACTURE OF THE LOWER END OF THE RADIUS.

BY R. J. LEVIS, M.D., PHILADELPHIA.

The correct nature and mechanism of the ordinary form of fracture of the lower end of the radius is now, after much controversy, generally admitted and properly comprehended. With this proper understanding the indications of treatment become rational and decisive. In the usual and very characteristic fracture of the carpal end of the radius the primary line of the fracture is, with little tendency to deviation, *transverse* in direction. Associated lines of fracture are generally those of comminution of the lower fragment, and are caused by the upper fragment being driven vertically into it and splitting it, usually in directions towards its articular surface. The displacement of the lower fragment is towards the dorsal aspect of the forearm, and its articular surface is inclined in the same direction, abnormally presenting backwards and upwards.

The mechanism of the fracture is its production by falls upon the palm of the hand, which, with the carpus, undergoes extreme extension, and the fracture is caused by an *act of leverage* or *transverse strain*. This direction of force has also been called *cross-breaking strain*. In this fracture, actual displacement of the lower fragment may not exist at all, or it may be to the extent of complete separation from contact with the broken surfaces, varying with the amount of force applied and with the retaining influence of the surrounding dense structures.

The first essential of the treatment of fracture of the lower end of the radius is *the complete reduction of the displacement*. The action of replacement must be directed to the lower fragment itself. The reduction of the fracture can usually be thoroughly effected, under anesthesia, by *strong extension applied to the hand, associated with forceful flexion of the wrist, and with pressure applied directly on the dorsal surface of the lower fragment*. Unless vertical splitting or comminution of the lower fragment

exists, the maintaining of partial flexion of the wrist, with pressure of a pad on the dorsal surface of the fragment, will prevent return of deformity. With the object of retaining the apposition of the fractured surfaces, by overcoming displacing forces, I have practiced for many years on the principles involved in the splint here illustrated, the application of which will not require much description. In the treatment of fracture of the lower end of the radius it is essential that proper allowance be made for the curvature of the anterior or palmar surface of this part of the bone. This is insured in the splint which I have devised, which follows correctly the radial curvature; and the fixing of the thenar and hypothenar eminences of the hand in their moulded beds, maintains the splint immovably in its correct position with reference to the radial



curve. To neglect of complete primary reduction of the displacement of the lower fragment, and to inefficient restoration and retention of the normal radial curve, are due the frequent unfortunate sequences of this fracture.

The splint is made of copper, so as to be readily conformable by bending to suit the peculiarities of size and form of forearms. The slight roughness left on back of splint from perforations is for the purpose of keeping the bandage from slipping. It is nickel-plated to prevent oxidation. The splint will usually fit the forearm so accurately that but little padding will be required, and a piece of woven lint, or of cotton or woollen flannel is all that is necessary for its lining. No dorsal splint is needed, but, as before referred to, a small pad will, in most

cases, be required over the dorsal surface of the lower fragment. For retention of the splint an ordinary bandage, two inches and a half to three inches wide, is all that is necessary. This splint has the merits of being applicable to all cases of fracture of the lower end of the radius, and also to many other injuries involving the forearm and wrist, and, as now supplied, is very inexpensive. It is manufactured by J. Ellwood Lee, 435 Walnut Street, Philadelphia, Pa.

ERRORS IN THE DIAGNOSIS OF PREGNANCY.—Professor Pajot, in a clinical lecture, observed that he wished to refer to a case which would prove of great value to the pupils, as putting them on their guard in relation to faults in the diagnosis of pregnancy. Such faults have been committed by men of the highest eminence, for if in 95 cases out of the 100 diagnosis is quite easy, in some others it is attended with extraordinary difficulty. In this case, of recent occurrence, such a fault had been committed by men in a high position, one of them enjoying great celebrity. In place of hesitating to communicate the case Professor Pajot brings it prominently forward, as it exhibits the precise rule which should be observed on these difficult occasions, and may save the reputation of the practitioner and even the life of the patient. A lady, thirty-five years of age, had a child when she was twenty, after a laborious labor requiring the forceps, and followed by a vesico-vaginal fistula. Since then she has had two labors, both quite easy. After the last of these, eight years ago, she suffered greatly from menorrhagia; but having five years since begun to introduce a large sponge into the vagina, for the purpose of sustaining the uterus, which had descended considerably, and absorbing the urine from the vesico-vaginal fistula, the menorrhagia ceased and was succeeded by irregular and sparing menstruation. Having become a widow she re-married, and coition was always performed with the sponge at the bottom of the vagina. Last summer she consulted Professor Pajot because her abdomen had greatly enlarged and she wished to know whether she was pregnant. Having removed the sponge he proceeded to examine her, and found the perineum very lax and easily depressed, a small vesico-vaginal fistula still existing. The cervix, in the erect posture, descended to within a few centimetres of the vulva, and was flattened, small, hard, atrophied and colorless. The orifice was but slightly developed. The uterus rose largely out of the pelvis and was very mobile, but its oscillations were not communicated to the cervix. Professor Pajot delayed giving his opinion on the case for a fortnight, when the patient declared that she felt the child move; but the foetal heart could not be heard and the opinion was still withheld. Meanwhile an accoucheur and hospital surgeon was consulted, who, after an atten-

tive examination, declared that an ovarian cyst existed. This alarming the patient, a celebrated laparotomist was consulted, who stated that a large fibrous tumor of the uterus existed and advised an operation. Three weeks after this last consultation, the patient having taken some very violent purgatives, gave birth to a child between seven and eight months old, all traces of the tumor disappearing. "Faults like these are committed only because old counsels which I have long since delivered have been forgotten. In these difficult and obscure cases, I said there is a simple line of conduct to be followed, which is both useful and prudent, and never compromises the health or life of the patient nor the reputation of the practitioner. This is *expectation*; we must know how to wait. If there is some pressing indication, of course we must fulfil it; for, when life is menaced, what matter is it about the pregnancy? But, as a general rule, neither the health nor the life of the patient is in question. The woman desires to know whether she is or is not pregnant. And as long as the problem does not appear to be soluble with certainty we should make no resolutions. Let us wait, and above all things wait without acting, if nothing creates an absolute necessity for action. Time is the best of all our means of diagnosis."—*Press Med. Belge*, Sept. 7, 1884; *Med. Times*.

FEVERS—GENERAL TREATMENT.—Professor Da Costa gives the following general rules for the treatment of fevers:

1. Reduce the temperature. The cold bath will do this most rapidly and certainly, but it is troublesome, and not altogether free from danger, and should therefore only be used as a last resort. Quinine in full doses is safer, and may usually be relied upon. It should not, however, be repeated too often, as it may produce alarming cerebral symptoms, with diarrhoea and general perturbation.

2. Lessen the rapidity of the circulation. Aconite is the best remedy here, especially if the pulse is full and frequent, but if the circulation is weak, digitalis will act better. Professor Da Costa does not, however, often give either. He prefers to endeavor to reduce the temperature, and so indirectly to control the circulation.

3. Keep up the secretions. Remove the waste of the tissues by diuretics, diaphoretics, and laxatives.

4. Nourish the patient. "Don't starve a fever." Give milk, beef juice, and other light nutritious food in small quantities, but at frequent intervals. Give the patient plenty of fluids also. Slightly acidulated drinks will be found to be both grateful and beneficial.

Professor Da Costa's experience has been that typhoid-fever patients do better, as a rule, on the dilute nitro-muriatic-acid treatment than on any

other of the many that have been proposed. It controls the diarrhoea to some extent and aids digestion. He generally orders twenty drops of it to be taken every four hours in water or syrup. The circulation is to be sustained at the same time, and the heart's action steadied by the administration of quinine in tonic doses—gr. vi-x daily; or, better still, by alcohol in small and frequently repeated doses. If the discharges from the bowels exceed three a day, or if they are excessive in quantity, they must be lessened by opium or opium and bismuth; or if the stomach be irritable, by opium and carbolic acid, or carbolic acid and bismuth. If these remedies prove unavailing, a combination of nitrate of silver or sulphate of copper with opium will usually be found effective.

For the tympanites, Professor Da Costa recommends cold-water applications to the abdomen, injections of vinegar and water, or turpentine stupes externally, combined with the internal administration of ol. terebinthinæ gtt. v-x and morphinæ sulph., gr. $\frac{1}{2}$ every two or three hours. The latter plan will be especially valuable if the tympanites co-exist with a dry, glazed and fissured tongue. The very high temperature that sometimes develops can be most safely and efficiently lowered by either the cold bath or by ice-water cloths on the abdomen.

The other complications are to be treated as they arise.—*Med. Bulletin*, January.

COMPLETE ASPIRATION.—David Christie, L. R. C. P. Ed., etc., Medical Officer of Rossguill Dispensary, writes:—

For some years past there has been much written regarding the use of the aspirator in cases of pleuritic effusion, and the talent displayed on this subject is creditable to the medical profession; but in using the aspirator there has been one thing omitted that mars or nearly destroys its utility. I have waited more than two years for some one to find it out, but, strange to say, in vain.

The thing is as simple as making an egg stand on its end *when you know it*, and the only mystery about it is that no one seems to have thought of it. I have tried partial aspiration as it is usually performed, and find that the pleural cavity refills in a short time; after complete aspiration it does not. The way it is managed is very safe and simple. I put a broad bandage round the chest that can be laced behind like a corset; then as I pump the fluid *out*, I press the ribs *in* by tightening the bandage. I think when I do so it is unnecessary for me to explain that I prevent any internal organ from being displaced (at the same time keeping them at a proper pressure), and the ribs by their elasticity from acting as a suction pump to cause a re-accumulation of fluid. I allow the bandage to remain on for some days. Any one who understands the action of a pump and a

syphon requires no further explanation. Many imagine they do, but are mistaken; these I would advise to consult "Ganot's Physics." After a certain amount of fluid has escaped, dragging pains set in. Tightening the bandage instantly gives relief. Alternate aspirating and lacing should be continued until all is removed; then there is likely to be a fit of spasmodic coughing; the patient may spit some frothy mucus tinged with blood, but all such symptoms pass off in a few minutes, and do not return—at least, that has been my experience.

I may add that the needle should be put in at such an angle that, after piercing the costal pleura, the point can be made to touch it again, so that when the pleuræ approach each other the lung may not be wounded; and when necessary the pleural cavity should be made antiseptically clean. *Med. Press*, Jan. 28th.

TREATMENT OF BRONCHITIS—WOOD.—It is not generally known that alkalies in large doses are amongst the most efficient of sedative expectorants. The citrate of potassium is much the most eligible for administering alkaline expectorants; of it half to one ounce should be given in 14 hours. The following prescription has been tested during four to five years, and found to be much the most reliable and sedative cough mixture that I have ever used:—R. Citrate of potash, one ounce; lemon-juice, two ounces; syrup of ipecac, half ounce; syrup enough for six ounces. Dose—Tablespoonful four to six times a day. When there is a good deal of cough or any excessive susceptibility of the bowels to loosening medicine, paregoric should be added in small quantity. The ipecac should be varied according to the susceptibility of the patient's stomach. Sometimes it can be advantageously substituted by tartar emetic. Usually two to three days of such medication will establish free expectoration. Then the stimulant expectorants are required, or squills and seneca, the former being the more valuable, though I cannot affirm that I have obtained positive results from their use, and think much of their reputation is based upon tradition and natural tendency of the disease to subside. Even squills is inferior to the mur. of ammonia. Like all ammoniacal preparations, this must be given at short intervals to maintain constancy of effect. The action of the single dose can scarcely last over two hours. Its acridity and disagreeableness may be somewhat covered by glycerine. In very large amounts all ammonia salts are capable of acting on the crisis of the blood as alkalies, and causing great vital depression. The value of copiba in chronic bronchitis has been long recognized, and it may sometimes be used with advantage in obstinate subacute bronchitis. When the "cold" in children is obstinate, "syrup of garlic" is very efficacious. But the stimulant expectorant which in my hands has almost replaced others of the class

is the oil of eucalyptus. It may be administered in ordinary cases of adults to the amount of about forty minims a day. Its taste is so pre-eminently disagreeable that it should be given in capsules, each of which may contain ten minims; or, if the patient prefer, two capsules of five minims each may be taken at a dose. The oil appears to be slowly absorbed and eliminated, so that four times a day is often enough. In emulsion it is very apt to cause unpleasant eructations, but in capsules is usually well borne. Some stomachs will not tolerate it. Counter-irritation is very useful; the oil of amber, an old remedy, is especially valuable in young children who have so often marked nervous disturbances and a tendency to collapse, diluted with one to three parts of sweet oil, applied to chest upon saturated flannel; it sometimes acts very happily in allaying nervousness as well as internal congestion.—*Ther. Gaz.*

VACUOLATION OF THE BRAIN.—Dr. J. C. Shaw read a paper before the New York Neurological Society, Feb. 3, 1885, on this subject, and showed a specimen.

Dr. Peters stated that very interesting cases were to be found on record in the "Transactions of the Pathological Society of London."

Dr. Parsons had never seen vacuoles of the brain of the size of those shown in the specimen. He had seen smaller ones. His impression was in accordance with the views expressed in the paper with regard to the origin of the enlargement of these perivascular spaces.

Dr. Weber thought that the vacuoles in this brain might be connected with septic fever, which certainly must have taken place during the man's life. He was inclined to think that there might have been infarctions in the brain which might have something to do with such immense vacuoles. He wished to know if Dr. Shaw had examined the brain soon after death.

Dr. Shaw said that he had done so the next day. He had cut into the brain afterward and found these cavities. There was nothing on the outer surface of the brain to indicate them.

Dr. Weber asked if Dr. Shaw really believed the larger-sized ones to be real vacuoles.

Dr. Shaw said that he really did.

Dr. Weber then asked if vacuoles as large as these had ever before been seen by Dr. Shaw or by any one.

Dr. Shaw stated that no one had seen them so large. He had not, at all events. The largest he had ever seen were of the size of a small nut.

Dr. Weber stated that the largest he had ever seen were as large as a pea, drawn out. They were of the size of the smaller ones surrounding the large ones in the brain that had been shown. In this respect he considered the specimen unique.

Dr. Shaw said that the reason he had presented

it was because it was an extraordinary specimen ; a great many cases were reported where there were no vacuoles. This man had certainly been subject to septic trouble. Dr. Shaw asked if those cyst cavities were not due to hæmorrhage.

Dr. Weber thought that the man probably had septic pleurisy. There might have been emboli carried into the brain ; certainly there was septic matter coursing through the arteries. In the cases he had known of there had been no structural disease going on.

It had struck Dr. Shaw that possibly thrombosis might have taken place in some of the small vacuoles, and that a large number of them might have been blocked up in that manner. The explanation that the perivascular spaces had been dilated was not a very good explanation for cavities of such large size.—*N. Y. Med. Journal.*

ADDISON'S DISEASE.—The details of the post-mortem and the microscopical appearances in a case of Addison's disease are given by Professor Cacciola, of Padua. (*London Med. Record*, Jan 15, 1885.) The patient, a man-servant, thirty-five years of age, died a year and a half after the skin had begun to bronze. The discoloration, with muscular weakness, had steadily increased. Febrile attacks occurred from time to time, and the patient died in one, delirious and convulsed. After death, beyond a certain softness of the brain, the nervous system, including the brain, the spinal cord, and sympathetic nerve, was found absolutely normal. The semilunar ganglia and solar plexus especially were carefully examined. The suprarenal capsules, on the contrary, were greatly altered. They were enveloped in a mass of fat and fibrous tissue, closely adherent to them. Each capsule was about the size and shape of a hen's egg, and weighed about thirty-five grammes. On section, the organs were seen to consist of a thick fibrous capsule of lardaceous appearance and tendinous consistence, sending prolongations inward. Between these prolongations were caseous substance and calcareous masses. The fibrous capsule and septa consisted of a thick connective tissue, with accumulations of leucocytes in course of degeneration. The contents of the spaces between the septa were made up of albuminoid detritus and oil-globules. In the central portion of the fibrous mass the connective tissue was calcified. Schizomycetes were looked for without success, but it is especially mentioned that some fat globules looked like Koch's bacilli colored by Weigert's method. There was little noteworthy amongst the other pathological conditions. There was, however, engorgement of the lymphatic follicles and of the agminated glands of the intestinal mucous membrane. The kidneys also were enlarged.—*Boston Med. Journal.*

CAFFEINE AS A SUBSTITUTE FOR DIGITALIS.—

Dr. J. Stewart, in *Can. Med. and Surg. Journal*, says : In the form of a double salt, as natrobenzoate, its action may be summed up as follows :

1. It strengthens, slows and steadies a weak fast, and irregular heart.

2. It quickly acts as a diuretic in cardiac dropsy, owing to its power of (a) raising the blood-pressure, and (b) of stimulating the secreting structures of the kidneys.

3. It is of marked use in the same class of cases as digitalis is. It differs, however, from that drug, in the following particulars : (a) It is less powerful as a cardiac tonic ; (b) it is a more powerful and prompt diuretic, and for this reason it gives relief quicker from all the troublesome subjective symptoms of cardiac failure.

It is probable that results obtainable from neither of these drugs, when given singly, could be brought about if caffeine was given first and its effects kept up until the cumulative action of digitalis could be made manifest. By combining the power of digitalis with the rapidity of action of caffeine we may get the advantages of both drugs with little of the disadvantages of either. There is no published evidence relating to these points, however.

Dose and mode of administration of Caffeine. The dose of any of the double salts should not exceed thirty grains in the twenty-four hours, this quantity being equal to about twenty grains of the pure alkaloid. Usually half the above dose will answer all purposes. The double salts are prepared by Merck, of Darmstadt, but have not as yet found their way to this side of the Atlantic. They, however, can be prepared extemporaneously. The following formula contains in each tablespoonful about one gram (fifteen grains) of caffeine :

Caffeine.....	15.00 (gr. 230) ;
Benzoate of Soda....	15.00 (gr. 230) ;
Water.....	250.00 (3viij).

The doses of caffeine (two or three grains) usually ordered are quite inadequate to act either as diuretics or cardiac tonics.

SO-CALLED SPECIFIC TREATMENT OF TYPHOID FEVER.—Dr. J. W. Hawkins, *Kansas City Medical Record*, Feby, 1885, says: It is said by medical writers of the present day that there is no known specific treatment for typhoid fever. We are gravely told that "the abortive plan by the use of calomel is the only treatment that can be considered ætiological or casual." To this statement I respectfully demur. If calomel aborts the fever in fifteen to twenty days, the bromide-of-potassium treatment will do it in seven to ten days. The bromide of potassium is a medicine (unlike calomel) attended by no bad results, and upon it we can confidently rely. It may be given in any and all stages of the fever—first, second, third, fourth,

fifth or sixth week. If you see the patient on the first or last day of the fever, begin at once to administer the antidote—bromide of potassium. In the whole metasynergetic cycle of remedies for typhoid fever the bromide of potassium stands at the head. It accomplishes what no other known remedy has done, when properly administered. It usually arrests the fever in from seven to ten days after beginning its use. If the treatment is commenced at the beginning of the attack, five-grain doses administered every three hours during the day only, and repeated daily, will usually be sufficient. But if in the last stage, from fifteen to forty grains will sometimes be required. In the last stage of a very severe case, when death seemed almost inevitable, I gave more than two hundred grains in twenty-four hours, producing no gastric disturbance whatever. The patient recovered. Hence from this and other like cases I am led to believe that we have a specific for enteric fever.

The truth of this has since been verified in the treatment of ten additional cases, the fever in every case being arrested in from seven to ten days. I think I am not talking too forcibly when I say that bromide of potassium is as much a specific for typhoid fever as the sulphate of quinia is for (ague) intermittent fever.

HOW TO SEE ONE'S OWN RETINAL VESSELS.—Dr. Maher, of Sydney (*Australasian Med. Gazette*, Nov. '84), describes a new method by which this may be accomplished.

Standing a short distance (ten or twenty feet) from a light gas jet, in a dark room, and covering one eye, say the left, with the left hand, the observer takes between the forefinger and thumb of the right a strong convex lens, and holds it at about its focal distance in front of the right eye. Then, steadily gazing at the light through the centre of the lens, he shakes the lens rapidly backward and forward along its axis, or up and down or from side to side. After a few seconds the shadow of the fovea centralis appears in the axis of vision as a light yellow patch studded with dark coarse granules. Simultaneously the retinal vessels in the region of the yellow spot, including the finest capillaries, appear as dark cords against the yellow light. This appearance according to Dr. Maher, is not unlike plate 72 in the last edition of Nettleship's book on "Diseases of the Eye," except that the difference between the arteries and veins is not so marked, and that one gets a more extensive view, seeing the shadow of the retinal vessels as far as the optic disk. The outline of the shadow of the fovea centralis, which falls upon the most sensitive part of the retina, the yellow spot, is well defined, while the outline of the shadow of the optic disk cannot be distinctly seen, as it falls upon a much less sensitive part of the fundus. The shorter and more rapid the movements of the

lens, the sooner the shadows of the retinal vessels and fovea centralis appear, and the more distinctly are they seen.

Dr. Maher claims that this is a simple and easy way of demonstrating :

First.—That there are no blood-vessels in the fovea centralis.

Second.—That the structures in which the visual impulses originate must be behind the retinal vessels.

Third.—That the fovea centralis differs in structure from the other parts of the retina.—*Med. Record*.

PHLEGMASIA DOLENS.—It appears that notwithstanding the numerous works and discussions on phlegmasia alba dolens the subject has not yet been exhausted. Dr. Brun, of Paris, has just written a work on the subject which throws some new light on its symptomatology. He considers the disease under two forms. The first occurring as a malignant affection from the onset, and causing speedy death; the second appearing as incidental in the course of a general pathological condition. The first, or infectious form, has been well known since the time of Velpeau. The second form the author sub-divides into latent, common, and lymphangitic. The latent form comprises those cases of sudden death from dyspnoea in severe diseases and after childbirth, in which the autopsy shows venous thrombosis of the limb, from which the detached particles have been carried into the circulation and obstructed the pulmonary artery. The common form is passed over as it has been so often described. The lymphangitic form is described as presenting a bright rosy color, diffused pains, which disappear slowly, great increase in the temperature of the limb and long-persisting oedema. The complications are: periphlebitis, consecutive arteritis, gangrene, and especially pulmonary emboli. The author regards a pre-existing lesion of the vein as the pathogenic cause. It may be due to vitiated nutrition, cachexia, or some severe febrile condition. A part of his observations, however, show that the nervous system deserves a share of attention. The views advanced by other recent writers on this disease are also of interest. Dr. Esler reports in the *British Medical Journal*, September, 1884, two cases of phlegmasia dolens occurring on the right side of patients who had, during and after labor, lain continuously on the right side. Dr. Dill, of Belfast, believes that one position long maintained may have something to do with the affection, but holds that the wearing down of the system from hemorrhage and irritation of the womb often induces it. Dr. Macartney relates in the *Indian Medical Gazette*, of November, 1884, the case of a young soldier, who, after suffering pain in the iliac fossa with obstinate constipation for ten days, during which time his temperature rose regularly

each evening, suddenly experienced a severe pain in the left groin and the limb began to swell, reaching nearly twice the size of the normal leg. The pain was excruciating and not relieved by hypodermics of morphia. The swelling was uniform, elastic, but not pitting on pressure, there was œdema about the ankle. After four days improvement began, but was very slow, the limb being powerless, and attempts to move it causing dull aching pain. The author regards the case as one of phlegmasia dolens differing in no essential point from the disease as it occurs in lying-in women. The obstinate constipation, with pain in the left iliac fossa appears to have been the exciting cause, just as pressure of the foetal head in this region, followed by pain and malaise, is believed to produce the disease in puerperal woman. Another case is mentioned as having occurred in the same hospital a short time before, in a man recovering from enteric fever.—*Med. Record.*

PÔRTABLE ANTISEPTICS.—Dr. T. E. Hayward, of Haydock, writes: Professor Lister has recently recommended as a portable antiseptic, a saturated solution of corrosive sublimate in glycerine; a fluid drachm of this solution being sufficient to convert about four pints of water into one in a hundred solution. The glycerine solution, doubtless, occupies a comparatively small bulk, and is readily mixed with water; but it is not very convenient to manipulate in measuring small quantities, and, if the bottle containing it should be broken, or become uncorked while being carried with other things, the result is unpleasant. A much more handy way of carrying the corrosive sublimate is to prepare powders, each containing ten grains of the salt and chloride of ammonium. One of these mixtures will dissolve in a little water in a few seconds; and, on diluting up to a pint, a solution is obtained of the strength of one to nine hundred and sixty. A few of these powders, wrapped round with gutta serena tissue to avoid deliquescence, can readily be carried in the pocket-case. The well known fact that ammonium chloride aids the solution of corrosive sublimate in water, renders the above suggestion so obvious that it has, doubtless, occurred to many; and it has probably already appeared in print. In view, however, of the very great advantage to all surgeons in country practice of having so ready a means of preparing an antiseptic solution, it may be pardoned if attention is drawn to the matter.—*British Med. Jour.*, Oct. 18, 1884.

PHOSPHATIC CONCRETION OF THE BOWEL.—Some weeks ago a young girl of about 18 years presented herself at Prof. Pancoast's clinic, with an opening in the abdominal walls on the right side, at a point near the middle of a line drawn from the umbilicus to the anterior superior spinous

process of the ileum. The history of the case developed the fact that the wound was the result of an injury received some four years ago, and that during this time more or less pus had been discharged through the sinus. The patient having been anesthetized and the wound slightly enlarged, it was found that the finger could be carried directly into the peritoneal cavity. This was rather an unexpected disclosure, and so antiseptics had not been provided for. Prof. Pancoast found upon a coil of small intestine a hard mass, which, upon removal and examination, proved to be a phosphatic concretion. The intestine was brought up to the mouth of the wound, a few bleeding orifices were secured by some fine black silk ligatures, and after all hemorrhage had ceased, the opening was dressed. The patient bore the operation remarkably well; on the second day a localized peritonitis set in, but this was soon controlled. The wound began to heal rapidly, except at its most dependent part. This occasioned the reopening of the parts, and another similar concretion was removed. From this time on the young woman did exceedingly well, the wound healing kindly, and before her discharge from the hospital she was presented to the class, apparently looking none the worse for the operation and her consequent protracted stay in the hospital.—*Col. & Clin. Record.*

TRACHEOTOMY WITHOUT A TUBE.—The danger and inconvenience connected with the tracheotomy-tube *per se*, are sufficiently great to have aroused a desire for some device which would obviate them. The matter was the subject of discussion before a late meeting of the Philadelphia Academy of Medicine. Dr. J. B. Roberts said he had had so much difficulty in keeping the tube clear that he had discarded it entirely, and instead cut out a rectangular piece of the trachea and stitched the edge of the opening to the skin. He found this to answer better than the double canula which is liable to become choked with the secretion. Dr. Packard had operated in this manner, but feared to adopt it as a general rule lest constriction of the trachea occur through cicatrization of the opening on healing. He instanced one case in which this had occurred. He thought the testimony in favor of tracheotomy without a tube was, however, very strong. Dr. J. H. Brinton recalled two cases in which the tube had been dispensed with. The membrane was readily ejected, and there was far less trouble than from the tube. Both cases, however, died from diphtheritic infection. Dr. Nancrede regarded the danger from ulceration from the irritation of the tube as sufficiently great to warrant the adoption of such a substitute for it as had been suggested, and the sentiment of the meeting was in favor of according a trial to the method of performing tracheotomy

which should dispense with the canula.—*Med. Age*, Jan. 10th.—*Analectic*.

ACUTE BRIGHT'S DISEASE.—In Professor A. L. Loomis recent treatise on "Practical Medicine," the author reviews the subject of treatment by diaphoretics and hydragogue cathartics. He states that he has been convinced for some years that the depurative method was wrong, and gives as the three indications: the elimination of urea and its allies, the removal of inflammatory products from the tubules, and the counteraction of the effect of urea and its waste products upon the nervous system. For this purpose the patient is put to bed, frequent dry cups are applied over the loins, and infusion of digitalis is given internally. This may be supplemented with acetate of potassium, spirits of nitrous ether, or some other mild diuretic. The bowels are of course kept open, and the skin moist. If severe uræmic symptoms appear, hydragogue cathartics and hot-air baths may be temporarily resorted to. Milk should be the only article of diet, and water is the best diuretic.

The view taken as to the utility of digitalis and the potash salts in nephritis, is sustained by the clinical experience of nearly all English observers from the time of Bright.—*N. Y. Med. Record*, January 3rd.

LANCING CHILDREN'S GUMS.—In the discussion of this subject before the Medical Society of London, Mr. Hamilton Cartwright (dentist) was distinctly of opinion that both diarrhoea and convulsions might be caused by dentition. There were two conditions under which lancing the gums is indicated: 1. If the gum is tense and glistening at the epoch when the tooth is about to come forward, by cutting into the sac of the tooth great and immediate relief is afforded. 2. In an inflammatory condition of the gums with tumidity, but without the extreme tension of the first class of cases, incision gives relief. In the latter class of cases the treatment is empirical but none the less successful.

Dr. C. J. Hare said it was to him a matter of great surprise and regret that the profession should so blindly give way to fashion as it had done on many points. Hundreds of lives had been lost by abandoning the use of bleeding; and among the forms of bleeding, the practice of lancing the gums, that is, bleeding from the gums, is one that deserves to be revived or continued. Dr. Webb had seen so many children on the point of death saved by lancing the gums that he regards it as a most valuable method of treatment.—*Med. Med. Four.*, Jan. 31st.

HINTS ON THE USE OF DRAINAGE TUBES.—In the *Journal of the American Medical Association*, Jan. 3rd, 1885, Dr. H. L. Getz, of Marshalltown, Iowa says:—"Some months ago we had occasion

to evacuate a pelvic abscess, and use a drainage tube for through drainage. Not having at hand at the time a regular drainage tube, we constructed one out of a piece of plain (small size) rubber tubing. After being in the opening for several days, we desired to replace it by another tube; we attempted to remove it; but found that the openings in the tissues through which the tube had passed, had contracted so as to hold tightly the tube, and although we made but slight traction, anticipating the possibility of the tube's breaking, to our extreme discomfort and dissatisfaction we soon realized that our anticipations were realities, a portion of the tube, an inch in length, remaining within the pelvic cavity.

We succeeded in removing it by dilating the opening through which the tube passed; then introducing a small blunt hook, we succeeded in drawing the piece of tube into position, so that it was easily grasped by a pair of forceps and extracted, much to our satisfaction, and with a vow that in the future we shall select with caution our material for drainage tubes.

A hint on the removal of tubes, and also upon their introduction, may not be out of place here; under circumstances as above described where the tissues firmly hold the tube, we should adopt the plan of inserting within the tube a dilator of some kind, with which to dilate the tissues before we attempt to withdraw the tube.

As a satisfactory method of introducing drainage tubes, we have found that where a trocar-canula was necessary to evacuate the contents of a cyst or an abscess, by taking the precaution to use a canula a trifle larger than the drainage tube to be used, the latter could be conveniently passed through the canula to position, and then the canula withdrawn.

PARALYSIS FOLLOWING HYPODERMIC INJECTIONS OF ETHER.—Arnozan ("Gaz. hebdomadaire de méd. de chir.") contributes a long article on this subject, in which he cites a number of interesting cases. In several instances in which injections were made under the skin of the posterior aspect of the forearm, paralysis of the extensors was noted within a few minutes. Under the use of the constant current the condition eventually disappeared. In one case a deep injection into the thigh was immediately followed by darting pains, which persisted for two weeks. The leg became livid, and wasted away, and the reaction of degeneration was observed. The patient subsequently developed a trophic ulcer on the heel, and improved very slowly, though under treatment for a year. The writer thinks that the phenomena described are really symptomatic of neuritis, which is due to the irritating action of the ether that has been deposited in the neighborhood of the nerve. [It is to be hoped that the publication of these will lead to more caution in those who are accus-

toned to resort freely to hypodermic injections of ether, brandy, and even ammonia, in cases of collapse.] Ed.

TREATMENT OF NASAL POLYPI.—Dr. Richardson, in the *Asclepiad*, recommends the use of sodium ethylate in the treatment of nasal polypus. The caustic agent is applied by means of a probe made of soft cotton-wool, twisted into shape on the points of a pair of forceps. The cotton probe is saturated with the ethylate, and then plunged into the substance of the polypus. On removing the cotton it commonly happens that the patient can expel the whole mass of destroyed polypus in a semi-fluid form, by blowing the nose sharply. A second application ought to be made with a view of destroying the base of the polypus. The mode of action is said to be sufficiently clear. The ethylate is decomposed by contact with the water of the polypus into caustic soda and alcohol; the latter coagulates the albuminoids, and the former acts as a powerful caustic. With the exception of some burning pain, no unpleasant effects seem to follow the use of this method.—*Weekly Medical Review*, February 28, 1885.

LAPAROTOMY FOR GUN-SHOT WOUND.—The first successful case of laparotomy for gun-shot wound done in this country, and the second on record, is reported in the *New York Med. Journal*, of Feb. 14, by Dr. W. T. Bull. A man shot in the abdomen by a bullet from a revolver (caliber No. 32), was admitted into the Chambers St. Hospital, New York, where, twelve hours after the accident, Dr. Bull saw him. The wound was situated at a point an inch and a half below the navel, and an inch and a half to the left of the median line. Seventeen hours after, having convinced himself by probing the wound that the bullet had entered the abdomen, Dr. Bull made a median incision through the abdominal wall. The gut presented, and on careful examination seven perforations were found. These were all closed with silk sutures. The search was continued, and the bullet was at last found lodged in the wall of the sigmoid flexure. The wound in the abdomen was closed after the cavity had been thoroughly cleansed with a solution of carbolic acid (two and a half per cent). As a preliminary to the operation carbolic acid by means of the spray was diffused through the room, in which was maintained a temperature of 80° F. All solutions were used warm.—*Med. Review*.

EXTIRPATION, BY LAPAROTOMY, OF A HYDATID CYST OF THE LIVER.—Dr. Gutierrez reports this curious case in *El Diceamen (Le Progrès Medical)*. A boy, 8 years of age, suffered from a tumor situated in the right iliac fossa and as large as a foetal head. Capillary puncture gave a clear fluid con-

taining numerous hooklets, which were insignificant. It having been decided to extirpate the tumor, the right side of the abdomen was opened by an oblique incision, and the tumor dissected from its adhesions to the epiploon, of which a portion was also removed to avoid its mortification. After opening the cysts, which had increased rapidly in size after the exploratory puncture, there was discharged with the fluid the great pouch or hydatid, which had as its external envelope the thickened capsule of Glisson, which the hydatid had by degrees disengaged from the external surface of the liver until it had lodged in the iliac fossa; the operator extirpated the fibrous envelope from its hepatic attachment to prevent any suppuration that might compromise the result of such a brilliant operation. He then applied three sets of sutures, very fine catgut, including first the peritoneum, then the divided muscles, and, finally the skin, using Lister's dressings. There was not the slightest trace of peritonitis, the reaction from the effects of the operation was slow; the wound healed perfectly, however, and digestion was normal.—*Four. Am. Med. Association*.

IODOFORM IN THE TREATMENT OF COMPOUND FRACTURES.—Bach (Inaug.-Diss, "Centralbl. f. Chir.") speaks highly of the direct application of powdered iodoform to open fractures. The powder is sprinkled upon salicylic cotton, and placed over the wound. Over this is applied a quantity of iodoform gauze, and the whole is secured with a plaster-of-Paris bandage. Of twenty-eight cases which were thus treated, sixteen ended in perfect recovery. The bandages were not disturbed during the entire process of healing. In another series of twenty cases, twelve were cured. The writer arrives at the conclusion that the treatment with "iodoform-scabbing" (*Iodoformschorferapie*) without drainage, is to be recommended in all cases of compound fracture in which the laceration of the soft parts is not too extensive. A neglected wound, in which there are numerous pockets filled with pus, is a contra-indication to this method of procedure.—*N. Y. Med. Journal*.

ERGOT AS A MEANS OF DIAGNOSIS.—Dr. J. W. Elliott in reporting five cases of ovariectomy in the *Boston Medical and Surgical Journal*, January 29, notes a use of ergot, which seems original with him. There was a very large immovable tumor, larger than a hen's egg, in the hollow of the sacrum somewhat to the right side. The uterus was three and a half inches deep and in left lateral retroversion. The tumor and uterus seemed blended into one mass. It was very difficult to determine what the tumor was and to what it was attached. To assist in determining this point Dr. Elliott administered ergotin pills until the uterus became fully and firmly contracted, when he found

that organ harder than the tumor and of decidedly different consistency, from which he was led to conclude that the tumor was not growing from the uterus, but only crowded against it.—*Med. Review.*

FOLLICULAR PHARYNGITIS.—E. S. Billings, M.D., writes: Will you please inform me through the columns of *The Monthly* what I shall do for an old case of follicular pharyngitis? It is one of the most obstinate cases I have ever dealt with, and I have exhausted all the means I know of, and oblige.

[Wipe the diseased surfaces well with a solution of bicarbonate of soda, three drachms to the ounce of water. After this is thoroughly done, removing all the secretions, spray it well with a solution of nitrate of silver, from twenty to forty grains to the ounce of water. This should be repeated once or twice a week as the indications call for. As a rule we have no trouble in curing the cases we have met with in this manner.—ED]—*New Eng. Med. Mo.*, Jan.

CARBONATE OF AMMONIA IN SCARLET FEVER. Dr. A. W. Jackson, of Brooklyn, writes calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.—*Med. Record.*

PIN SWALLOWING.—In the *New York Medical Record* of Jan. 15th, 1885, I noticed an article on "Pin Swallowing." I paid very little attention to it, as the case was treated contrary to my teachings. On Feb. 2nd, about 4.30 p.m., Mr. G. H. E., came to my office in a great hurry and stated that his daughter Nettie, about 8 years old, had swallowed a large shawl pin. She placed the pin in her mouth to arrange the shawl around the shoulders, and while doing this threw back her head and down went the pin. I told him I was taught to give a brisk cathartic in such cases, but I believed it better to give plenty of bulky food, as I had read an article to that effect not long ago in some journal. He told me the child lived almost exclusively on bread, of which she ate enormously. I advised him to give plenty of food, no purgatives, and watch the stools. The pin was swallowed

February 2nd, 4 p.m.; evacuated in the centre of a mass of feces February 4th, 2 p.m., forty-six hours afterward. It measured $2\frac{3}{8}$ inches in length, with very sharp point, and a glass head somewhat larger than a buckshot. It passed away as it entered the mouth, head first.—*Dr. Wagner, in Col. & Clin. Record*

DANGER OF DIPHTHERIA CONTAGION.—Prof. Jacobi, (*New York Med. Journal*) says that many sore throats regarded as trivial are, in point of fact, diphtheria; especially those known as follicular tonsillitis. What to-day looks like one or more points covering the outlet of ducts, to-morrow may be a continuous membrane. Some mild cases of diphtheria are prolific of danger because they are apt to assume a chronic course without losing contagiousness. The throats of servants, nurses, and others who are in constant contact with the children of a household or school, should be from time to time inspected. There is as much diphtheria out of bed as in it; nearly as much out of doors as in-doors. Diphtheria is contagious, and probably has no spontaneous origin.

INJECTIONS OF ETHER AND IODOFORM IN COLD ABSCESS.—Professor Verneuil obtains a rapid cure in almost all his cases of cold abscess, abscess from diseased bone or from congestion, etc., by ethereal injections of iodoform of the strength of one in twenty. The abscess is first emptied by means of Potain's aspirator, and then receives from 100 to 300 grammes of the iodoform solution. By not exceeding this quantity (*i.e.*, five to fifteen grammes of iodoform) no fear of accidents need be felt. The liquid penetrates into all the anfractuosités and diverticula of the abscess, the ether becoming absorbed or evaporated, and the antiseptic agent being deposited uniformly on the pyogenic membrane, the action of which it modifies. This simple means, so exempt from danger and for ease of applications has proved highly successful, very large abscesses having yielded to three or four injections.—*Revue de Thérapeutique*, August 15, 1884.

SAVE THE FINGERS.—Dr. William D. Ronaldson of Philadelphia, writing to us on the subject of conservative surgery, reports two cases which show it is often better not to yield to the impulse to cut off a bad-looking finger. A. B., a brakeman on a railroad train, had his finger caught between the bumpers of the cars while endeavoring to couple them. The nail and flesh were torn completely off, leaving the distal extremity of the bone exposed. The injury was of such a nature that amputation of the ungual phalanx would have been permissible; but having cleansed the wound thoroughly with tepid water, a dressing of carbolized oil (1 to 15) and cosmoline was applied. The finger healed in three weeks, and, except for the loss of the nail,

was as serviceable as before. The second case was similar to this one, in treatment and results.—*Medical Record, Feb. 14th, 1885.*

IDIOPATHIC ANÆMIA.—A favorite prescription of Prof. Da Costa in marked idiopathic anæmia is :

R. Ferri sulph. 3 j.
Potassii carb. 3 j. M.
Ft. pil. No. xl.

Sig.—One after meals for first week ; increase dose in second week, etc.

If the patient is a female suspend treatment during menstruation.—*Col. and Clinical Record, January.*

ALCOHOL IN THE TREATMENT OF INSANITY.—Dr. W. B. Fletcher, Superintendent of the Indiana Hospital for the Insane, and Dr. R. M. Bucke, of the London, Ontario, Asylum have entirely abandoned the use of alcohol in any form in the treatment of the insane. They believe that their patients do just as well as before, and perhaps better.—*Med. Record.*

HIMROD'S ASTHMA CURE.—Dr. A. J. Campbell writes in the *Brit. Med. Journal*: "In Martindale's *Extra Pharmacopœia* there is an excellent substitute for Himrod's asthma cure, which I have tried and found very useful. Dissolve two ounces of nitrate of potassium in two ounces each of lobelia, stramonium leaves, and black tea well powdered ; mix well and dry thoroughly. A tea spoonful burned, and the fumes inhaled, generally gives immediate relief."

AN APPLICATION FOR OZÆNA.—The following is Vidal's formula, as employed at the Hôpital St. Louis ("Jour. de med. et de chir. prat." ; "Practitioner") :

Solution of chloride of zinc, 5 per cent. . . . 1 ounce ;
Boric acid 14 grains ;
Water 28 ounces ;
Ammonia-water, enough to neutralize the solution.

FORMULÆ.—Prof. Bartholow has frequently prescribed the oil of wintergreen in rheumatism, with excellent results. A useful combination is :

R. Ol. gaultheriæ 3 j
Acidi salicylici ʒ iv
Sodii biborat. 3 j
Syrup. picis liquidæ,
Aquæ anisi aa f 3 ij M.

Sig.—Dessertspoonful every four hours.

In chronic bronchitis with asthmatic breathing, Professor Bartholow prescrib. d, in the clinic :

R. Ext. grindeliæ fluidi
Ext. quebracho fluidi aa ʒ xx
Ammonii iodidi gr. v. M.

As a tonic in the asthenic type of fevers Prof. Gross advises the following :

R. Quiniæ sulphat. gr. ij
Tinct. ferri chloridi
Acid. hydrochlor. dilut. aa gtt. xv
Tinct. nucis vomicæ gtt. x
Syr. zingiberis f 3 j. M.
Sig.—This amount ter die,

Instead of nux vomica $\frac{1}{10}$ grain of strychniæ sulphas may be employed.—*Col. & Clin. Record.*

In lymphadenoma, following scarlet fever, in a girl of seventeen years, Prof. Da Costa prescribed

R. Acidi arseniosi gr. $\frac{1}{10}$
Ferri sulph. gr. ij M.
Sig.—The pill ter die.

Over the enlarged glands rub :

R. Ung. iodi
Ung. belladonnæ aa 3 ss.
Camphoræ gr. v. M.

In atonic dyspepsia, Professor Da Costa prescribed.

R. Tinct. nucis vomicæ gtt. x
Tinct. capsici gt. j
Tinct. cinchonæ comp. f 3 j M.
Sig.—Ter die.

To this was added pepsin, gr. iij-v, with each meal.

DR. OSLER'S GULSTONIAN LECTURES.—This year's lenten lectures at the Royal College of Physicians, London, were opened on Thursday, February 26th, by Dr. Osler, of Philadelphia, who choose for the subject of his Gulstonian Lectures the fascinating disease known as ulcerative endocarditis. His first lecture was devoted to the naked eye and microscopic pathology of the affection, its clinical history and etiology being left for discussion in the lectures to be delivered on Tuesday and Thursday in the following week. The lecture was mainly *ex tempore*, lasted the ideal forty-five minutes, and was unusually well attended. Dr. Osler, as might have been expected, was most cordially greeted, and there can be no doubt that his lecture was such as was well worth while his coming across the water to deliver.—*London Medical Times*, February 28, 1885.

KAIRIN.—Kairin, although comparatively little used as an antipyretic, has grown in favor particularly in France and to some extent in Germany. Its use has been more general in febrile diseases. Having been satisfactorily employed in pneumonia, scarlatina, measles, erysipelas, septicæmia, peritonitis, etc., it is considered a safe and valuable antipyretic, worthy of further trial. The usual dose of sulphate of kairin is about eight or ten grains every two hours till the temperature is reduced.

THE CANADA LANCET.

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The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

LACERATION OF THE PERINEUM.

A good deal, no doubt, of what even the most gifted medical journalist feels called upon to say is very stale and incipient to some of his readers. In this connection it is always well to remember that all are not specialists, nor have all reached the acme of universal medical knowledge. Moreover the bulk of the profession is scattered over the face of the country, far away from the centres of learning and concrete mental activity. What may be stale, and even incipient, to the college professor or hospital physician may be interesting and profitable reading to the general practitioner. Besides, the journalist does not pretend to write for the benefit of the specialist, or the few, but for his readers as a whole. This is our apology for referring to so common-place a subject as laceration of the female perineum.

The race of obstetricians just passing away gave themselves but little trouble or anxiety about the perineum. A partial rupture was regarded as of small consequence, while a more extensive one—if not complete, however deplored, yet was a thing to be patiently endured. Indeed, there is good ground for the belief that ruptures, both great and small, were not uncommon, all unknown to the learned attendant. Nor is it certain that even extensive lacerations do not occur without the knowledge of the supposed accomplished obstetrician of the present day. The former had some excuse for his lack of watchfulness, but the latter,

who is constantly admonished from every side, is scarcely able to furnish a valid excuse for his carelessness. Without doubt, lacerations of the perineum are becoming more frequent. It is not enough to say that, in the present day, cases which formerly were undetected, or, if detected, were not reported, are now more frequently discovered and made known, both to the patient and the profession. That is quite true, but, in addition, we know full well that artificial causes operate more extensively than formerly in producing this accident. The forceps is a great boon to woman and no one would abolish it, yet it is to its more common use that we must attribute the increased frequency, and often the more aggravated nature of perineal laceration. Of course, the perineum may be, and often is, torn by the natural efforts alone. Most of us have often been consulted by some old woman suffering, all unconsciously, from an ancient rupture of the perineum. She complains of falling of the womb, difficulty in making water, some kind of trouble about the lower bowel, besides a score of other troubles, but is utterly oblivious as to the real cause of all her suffering. Yet such a one might never have been delivered with forceps, and sustained the injury without any instrumental or undue interference.

No one will deny that the use of the forceps tends to greater liability to rupture. This arises from three causes at least. The first is the tendency under the excitement, and demoralization of the moment perhaps, to deliver too rapidly; secondly, delivery of the head while still grasped by the forceps; and thirdly, slipping of the instrument. Someone may be ready to exclaim that all these causes are avoidable. We think the experience of the most skilful contradicts such a position, and that the perineum will sometimes be ruptured while the forceps are held by the most "cunning" of hands. Rapid distension may be called for, or the tissues may have but little cohesion; uterine effort may be feeble or extinct, and the head may have to be delivered contrary to general rule, still grasped by the forceps; and a contracted pelvis, or a large, unyielding head, may render accurate manipulation impossible, and so cause a slipping of the instrument, an accident, of course, not always, though sometimes, followed by laceration. Few practitioners of extended experience, we feel convinced, but have had occasion to lament more

than once the presence of laceration, more or less serious, after a forceps delivery. Even Professor Goodell is not above confessing that such a casualty has occurred in his hands on several occasions. These remarks are not made in the interest of bunglers, but rather to make good the statement that the more frequent use of the forceps tends inevitably and unavoidably to an increase in the occurrence of the accident under consideration. After making due allowance for unavoidable cases, there is much room for the belief that a good deal of suffering is inflicted by the unskilful use of the forceps. It is manifestly the bounden duty of every obstetrician to study to maintain a cool head, a steady hand, and an avoidance of all the causes known to lead to this untoward accident.

When laceration occurs, as occur it will now and again, no one in his senses will leave the woman to her fate, that is, if the laceration be at all serious. The train of evil consequences following a considerable perineal rupture outstrips by far the consequences of an equal breach of continuity of tissue, not associated with the vital organs, in any other part of the body. Prolapse of the uterus, vesical and rectal protrusion, unhealthy vaginal and uterine discharges, erosions of the cervix and other uterine complications, difficult micturition, constipation, besides a host of general troubles, as neuralgia and indigestion, having their seat in reflex action, are a train of evils of so aggravated a nature as to call for the prompt execution of the measures best calculated to ward them off. The safest, best and only treatment, is the restoration of the part. Immediate closure of the breach is now insisted upon by the profession everywhere. For this several cogent reasons may be advanced. Delay in closing the wound exposes the patient to blood poisoning; experience shows that the primary operation carefully performed is almost always successful; the primary operation is comparatively easy, and can be readily performed, when necessary, without the aid of a skilled assistant. In the secondary operation the necessary dissection is the most painful and delicate part of the work; in the primary operation nothing of this kind is called for; the parts are simply brought into their natural place and held there by approved supports. Lately new methods have been proposed but the quilled suture still holds its place for all extensive rents. In slight rents a single simple suture is all that is re-

quired. Dr. Alloway, of Montreal, first recommended the single suture operation in all cases we believe, not involving the sphincter or bowel. Perfect coaptation is the great secret of success in union by first intention, in all wounds, and nowhere is this more true than in wounds of the perineum. The after treatment of these cases is of great consequence. The wound must be carefully guarded against the action of the urine and lochia, and some approved antiseptic should be used, not only as an application to the wound but also as an injection. The conclusion of the whole matter is, that the obstetrician of the present day must be on the alert for perineal rupture, and be prepared to repair it on the instant when it occurs.

SANITARY INSPECTION.

The history, character and progress of former epidemics of cholera in Europe point to the probability of an invasion of the disease in this country during the coming summer. It is therefore high time for the authorities to be aroused to the necessity of adopting such means as will prevent its incursion or mitigate its severity should it unfortunately reach our shores. The State Board of health for Illinois, in view of the expected invasion, has ordered a sanitary survey of the State and a house to house inspection, so that all sanitary defects and evils may be corrected as expeditiously and with as little expense as possible. The inspectors are authorized to request the prompt correction of all defects, and the removal of all nuisances as soon as they are discovered, and all persons neglecting or refusing to comply with the request shall be prosecuted according to law. The inspection will be conducted under the supervision of the health authorities wherever such exist, and where there is no such organization a health officer shall be appointed.

This action of the Illinois board is worthy of imitation, and we trust that immediate action will be taken by the authorities in our own city and elsewhere in the Dominion. It is important that this work be begun as soon as the weather will permit; and it is especially desirable that certain details be attended to at the earliest practicable moment. For example the emptying, disinfecting, filling with clean earth, or other necessary treatment of privy vaults, should be completed before warm weather

comes to interfere with such work, or before the appearance of a case of cholera makes it dangerous to attempt it. To this end, wherever the conditions make such action necessary, a proclamation or health notice should be issued, directing the immediate prosecution of such work.

THE ONTARIO ANATOMY ACT.

The bill before the Legislature of Ontario bids fair to become law, and we trust that no unforeseen circumstance will arise to prevent its passing in the shape in which it was amended by the special committee to which it was referred. The bill is in Dr. Baxter's hands, and we have every reason to believe that no serious opposition will be raised against its provisions when it reaches the third reading. There is very great need of such a measure; the supply of material obtained under the old act was wholly inadequate to the demand. The number of medical students has greatly increased while the amount of anatomical material remained about the same; during the past session the supply was wholly insufficient, and the teaching of practical anatomy was greatly retarded in consequence. The Act provides that the bodies of those found dead, or dying in public institutions, (Lunatic Asylums excepted), and not claimed by relatives, or friends who are willing to bear the funeral expenses, shall be handed over to the medical schools for anatomical purposes. This is the essential clause, and if passed, will, it is confidently believed, give an abundant supply of material. The remaining clauses provide for the appointment of inspectors and in a general way secure the machinery for the proper working of the Act.

"UNPROFESSIONAL" ADVERTISING.—An epidemic of diphtheria in Halifax, N.S., is made the occasion for a fresh outbreak of "unprofessional" advertising among our confreres down by the sea. A disgusted M.D. writes to the *Halifax Mail* in regard to the matter in the following terms:—"I was surprised to see by your issue of last night that this serious question has begun to be made a pretext for puff and quack advertisements by some few of our medical brethren in this city. This action on their part is reprehensible in the extreme, and most derogatory to our profession, and would not be tolerated

in England, or elsewhere in this country; it is also most prejudicial to the matter under consideration and the public good. All praise is due to Dr. Campbell for the stand he has taken in ventilating this important subject, but the same cannot be said respecting others, who are too palpably endeavoring to foist their names before the public in this irregular manner; and it is to be hoped that the press of Halifax will not prostitute their columns by allowing them to be channels for this discreditable system of spurious medical advertisement. It was only very lately that the leading medical journal of Canada had occasion to censure severely one or two medical men in this province for a similar offence, and it is to be sincerely hoped that this stain on our profession in these parts is not about to be increased by a repetition of these improper and unprofessional practices."

PNEUMONIC FEVER.—In an article on relapsing or intermittent pneumonia in the "British Medical Journal" of recent date by Sir Andrew Clark it is said: "Every one appears to have asked if pneumonia is not a fever, but scarcely any one has asked if pneumonia is really an inflammation." In this connection Andrew Clark refers to a lecture delivered by himself at the College of Physicians in 1866. These views were long since advanced by Professor Austin Flint, of New York, and are still held by him in his valuable work on the practice of medicine. He says that pneumonia is the local manifestation of a fever, and should be called "pneumonic fever." He gives the following reasons, with others, for the belief that it is a fever: The large quantity of exudation which is derived from the pulmonary artery—hence from carbonized and not from oxygenated blood—this exudation being ultimately completely absorbed, the air-cells returning to their normal condition. Moreover, pneumonia is never caused by the extension of any local process, such as abscess, gangrene, or any kind of local injury. Again, the disease is ushered in by a distinct rigor, and the temperature rises rapidly before there are any local manifestations. The spleen often becomes enlarged, and the patient becomes jaundiced.

MEDICAL JOURNAL ADDRESSES.—We have just received from the Illustrated Medical Journal Co., of Detroit, Michigan, several sets of their perfo-

rated, adhesive medical journal labels. The list includes besides the journals of the United States that are devoted to medicine, pharmacy and hygiene, those of the Provinces of Canada as well. Four complete sets will be mailed postpaid for fifty cents, on addressing the publishers above named. They are just what every physician needs for addressing his reprints for journal notice, and medical colleges for addressing their announcements for a similar purpose.

HYPOSULPHITE OF SODA AS A DISINFECTANT.—The difficulty of finding a satisfactory disinfectant with which to destroy fœtor in cases of cancerous ulcers, is well known. We have used a saturated solution of hyposulphite of soda added to an equal quantity of water, and found it exceedingly efficacious. The ulcerating surface was well syringed and washed with the solution, and was, then covered with rags steeped in the solution. The granulations were kept clean, and the fœtor was well kept under. It is cleanly, has no smell, does not stain, and is not expensive.

CLIMATE OF COLORADO.—Dr. R. B. Teller of Aspen, Colorado, writes that the climate and mineral waters of Glenwood and vicinity are exceedingly well adapted to the cure of rheumatism and phthisis. Phthisical patients have been benefited to an extent that would seem perfectly incredible to those not familiar with the climate. Persons suffering from either of the above diseases, or with asthmatic affections, he says, may rely upon obtaining certain relief in Colorado.

HALIFAX MEDICAL SOCIETY.—A meeting of the medical profession of Halifax, N.S., was held on the 14th ult., to organize a medical society. After some discussion the following officers were elected for the ensuing year:—President, Hon. Dr. Parker; Vice do. Dr. Rigby; Secretary-Treas. Dr. Lathern; Committee on by-laws, Drs. Cowie, Rigby and Campbell; Executive Committee, Drs. Tobin, Cowie, Farrell, Almon, Wickwire.

THE TREATMENT OF RINGWORM.—Mr. Alden Smith, in the "British Medical Journal," speaks very highly of a solution of chrysophanic acid in chloroform for the cure of ringworm. The chloroform will dissolve the fatty matter in the hair follicles, thus facilitating the acid in getting to the

parasite, which it destroys. The prescription is used in the strength of seven grains of the acid to the ounce of chloroform. The hair, if there be any to speak of, should be closely clipped.

NIGHT COUGH IN CHILDREN.—The occurrence of a troublesome night cough in children is met with frequently. Dr. McCoy, of Philadelphia, in an article in the *Mel. News* draws attention to this affection and claims that it is due in most cases to nasal catarrh with its accompanying secretion, etc. During the day the discharge passes away, but during the night it accumulates and causes irritation, or passes down the posterior nares and into the pharynx. The treatment recommended is to cleanse the nose before the child is put to bed by means of a spray composed of an aqueous solution of an alkali.

LOCAL ANÆSTHESIA.—It is said upon good authority that local anæsthesia may be readily produced by applying with a camel's hair brush the following mixture:

R Chloral,	
Camphor,	aa 3 j,
Morph. sulphat. . . .	3 ss,
Chloroform,	3 j. M.

Sig. To be applied with a brush to the area to be incised.

ONTARIO MEDICAL COUNCIL ELECTIONS.—We publish in another column the address of Dr. Allison to the electors of King's and Queen's territorial Division. So far there does not appear to be any opposition to the worthy doctor's candidature, and we hope to see him elected by acclamation.

Dr. A. S. Fraser, of Sarnia, has been appointed Returning Officer for the Western and St. Clair Territorial Division, *vice* Dr. Richardson, of Chatham deceased.

A CONJOINT SUMMER SESSION.—A summer course of lectures, clinical and practical, will be given by the acting staff of the Toronto General Hospital connected with the two medical schools. The session will commence on the 1st of May, and continue ten weeks. The lectures will be delivered in the theatre of the hospital. See announcement in another column.

CASE OF TRIPLETS.—Dr. Phelan, of Kingston, reports a case of confinement in which a woman

gave birth to three healthy living children, two girls and a boy—all living. She was 12 hours in labor before the first birth; 25 minutes later, the second child was born; and 35 minutes later, the third was born. Each child had a distinct placenta.

APPOINTMENTS.—Dr. A. C. Pantou, (Trinity) has been appointed to the chair of materia medica, and Dr. K. A. J. McKenzie, (McGill), to the chair of clinical surgery in the Medical College of Portland, Oregon. Dr. A. Robillard has been appointed a commissioner under the Liquor License Act.

Hon. Dr. Parker, of Halifax, Dr. Page, of Truro, and Dr. McGillvary, of Sydney, have been appointed members of the Nova Scotia Medical Board.

CORONER.—Dr. C. Sinclair, of Aylmer, has been appointed coroner for the Co. of Elgin, and Dr. A. C. Bowerman for the Co. of Prince Edward, Ont.

INDEX MEDICUS.—We are pleased to notice that this valuable monthly publication is to be revived. It will be published by Mr. Geo S. Davis of Detroit. The editors are Drs. Billings and Fletcher of Washington.

THE death of Prof. Frerichs, of Berlin, in announced in our Foreign exchanges. He was a man of great ability and his death is a serious loss to German medicine. The death of Dr. Ellerslie Wallace, of Philadelphia, is also noticed in our exchanges.

Notes, Queries and Replies.

BRITISH QUALIFICATIONS.

To the Editor of the "CANADA LANCET."

SIR,—In reply to Queror in last number of the "LANCET," I wish to say that I spent one month in the London hospitals, obtaining great insight into special and general diseases. There are some forty hospitals in the Metropolis, but the material is not presented to the best advantage *i. e.* for a graduate to learn much in a short time—more especially in the special sub-divisions of the science.

I attended the Edinburgh New Royal Infirmary for four months devoting four hours per diem to practical work, one hour to grinds and the remainder of the day to study, etc. I succeeded in passing the first conjoint examination of the R. C. P. & S., Ed., and the Faculty of P. & S. of

Glasgow. I may say the feeling of equality extended to a Canadian confrere, materially assisted my chances of gaining practical knowledge. I believe Glasgow also to be a good place to obtain practical instruction, as students are requested to familiarize themselves with the ward work.

I next took Cook's tickets from Scotland to Hamburg, Berlin, Vienna, Paris, London and intermediate points, costing \$75.00, with \$2.00 per day for hotel coupons, and extras additional while on the road. The expenses, when a permanent stay is made in any one place, can be made to suit circumstances. Much was seen that I never expected to see here, and my experience and confidence was advanced many years. Expenses on the ocean can be arranged to suit individual taste. I purchased a first-class return via Allan Line by Quebec and Halifax with R. R. reduced rates for an unlimited season. Expenses in Great Britain I should judge to be about \$5.00 to \$7.00 per week for a long period, with \$130.00 for examinations, \$25.00 for registration, and a few pounds for hospital fees. Extras according to special requirements. For the regulations of the respective corporations write to Dr. James 11 Albyn Place, Dr. J. Wyllie, R. Infirmary, Mr. Bell, F.R.C.S., Edinburgh, the secretaries of the triple, physician and surgeon qualifications.

The conjoint examination is written, clinical, and oral and lasts a week or more. The subjects are: Medicine (including Therapeutics, Medical Anatomy and Pathology), Clinical Medicine and Surgery, Surgery (including Surgical Anatomy, Operative Surgery and Surgical Pathology), Midwifery (including Gynæcology), Medical Jurisprudence and Hygiene. The ward examinations include both medical and surgical cases, besides testing urine and recognizing urinary crystals, etc., bandaging and the use of surgical instruments.

A Canadian must produce his diplomas and other certificates which they demand. The advantages received from the practical work should be the primary and the examinations the secondary object to take one's time and attention. In case of failure at the examination one has the privilege of trying again in three or six months after paying \$25.00 entrance fee which many are obliged to do.

W. F. FREEMAN.

WALKERTON, Ont.

USE OF PICROTOXINE.

To the Editor of the "Canada Lancet."

SIR,—Would some of your readers give their experience in the use of Picrotoxine in the sweating of phthisis, and also in what liquid it is best dissolved.

THERAPEUTIC.

New Brunswick, Mar., 85.

Books and Pamphlets.

THE LAW AND MEDICAL MEN, by R. V. Rogers, Jr. of Osgoode Hall Toronto, Barrister-at-Law. Toronto: Carswell and Co.,

This little work consisting of about 200 pages, fills a gap in the library of both the physician and lawyer. It deals with the laws relating to the practice of medicine, fees, (who should pay the same), civil and criminal malpractice, privileged communications, expert testimony, defamation, relations with patients, dissection, resurrection, etc., etc. In discussing the subject of malpractice he cites the following, page 61, (J. Woodward in *McCandless v. McWha* 22 Pa Rep. 261) "A patient is entitled to the benefit of the increased knowledge of the day. The physician or surgeon who assumes the healing art is bound to be up to the improvements of the day. The standard of ordinary skill is on the advance, and he who would not be found wanting must apply himself with all diligence to the most accredited sources of knowledge." Where would the fossilized members of the profession who never read a medical journal or any new work on medicine be found in the face of the above ruling?

The book is a very interesting and readable one and should find a place in every physician's library, in view of the fund of information it contains. The statements of law contained in the book are in nearly every instance the rulings of the judges in the particular cases, with citations. We would suggest to the author the propriety of printing the code of medical ethics, as an appendix, in the next edition.

THERAPEUTICS OF THE RESPIRATORY PASSAGES.—By Prosser James M.D. London.

This is one of the best of the monthly issues of "Wood's Library of Standard Medical Works." Every valuable medicament employed in the treatment of the affection of the respiratory passages is

subjected to impartial consideration. The chapters on alcohol, denutrients, and antipyretics are peculiarly instructive, clearly indicating that the author whilst free from the sentimental prejudices of the extremists, is yet gifted with that spirit of candour which should ever be the dominating influence in medical science. The book cannot be read by any practitioner without great profit.

DISEASES OF THE URINARY AND THE MALE SEXUAL ORGANS.—By W. T. Belfield, Chicago. W. Wood and Co: New York.

Dr. Belfield has had the advantage of practically studying the above diseases in a prolific region, and his book presents abundant proofs of his careful observation. In a large city like Chicago, teeming with a very fast population, with strong propensities to illicit pleasures, and exempt from abhorrence of facile divorce, the diseases treated of by Dr. B must constitute no trivial part of daily routine, and and if they are sedulously cultivated, the pecuniary results must be very enticing.

DOCTRINES OF THE CIRCULATION, by J. C. Dalton, M.D., Emeritus Prof. of Physiology, College of Physicians and Surgeons, New York. Philadelphia: Lea Brothers & Co. Toronto: Williamson & Co.

This is a most interesting and well written handbook of the doctrines of the Circulation from Aristotle, Praxagoras, School of Alexandria, Galen, Period of Renaissance, to the dawn of light on this subject, following the discoveries of the Professors of the Universities of Padua, Pisa, Bologna, and Rome. The author also gives the subsequent opinions of Servetus, of the transfer of the blood from the right side of the heart to the left, taking place in the lungs, and not through the septum of the ventricles; also the discovery of the valves in the veins by Fabricius ab Aquapendente, their form, and speculations on their use. He next refers to the doubts of Harvey regarding the correctness of these theories, and his subsequent discovery of the peripheral circulation from the arteries to the veins, and of the return circulation of the blood through the veins to the heart. Space will not permit further notice of the scope of this work, which is of great research, and one that we welcome as a valuable addition to medical literature.

Births, Marriages and Deaths.

On the 2nd ult, J. B. Howell, M.D., of Thornbury, aged 34 years.

On February 9th 1885, wife of Dr. A. McTavish, Staffa, Ont., aged 39 years.

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Original Communications.

OVARIOTOMY.

BY DR. A. M'DONALD, EDINBURGH.

Read before the Obstetrical Society of Edinburgh.

CASE I.—M. P., aged 23, unmarried, was admitted in January 24, 1884, complaining of a large swelling in the abdomen, of pain in the right side, of sickness, and of only being able to digest milk diet. Two years ago she suffered severe pain in right side and inability to eat. In August last she first noticed the swelling, and since that time it has rapidly increased in size. She had considerable menorrhagia and metrorrhagia from May till August last year.

Condition on admission.—Abdomen extended to size of eight or nine month's pregnancy by a tumor of slightly uneven outline, but, on the whole, of smooth contour. Tumor projects very far forward inferiorly, and seems to be more to the right than left side. Percussion note is dull over anterior surface of tumor, clear in flanks from back. Tumor appears to move slightly under anterior wall with forced inspiration. Measurement round umbilicus $35\frac{1}{4}$ inches; about $1\frac{1}{2}$ inches below umbilicus measurement is 38 inches. From right anterior superior spine to umbilicus, $9\frac{1}{4}$ inches. From left anterior superior spine to umbilicus $8\frac{3}{4}$ inches. From symphysis pubis to umbilicus, $8\frac{1}{4}$ inches. *Per vaginam.* Tumor presses down into anterior half of pelvis, displacing uterus to the left and backwards. Uterus appears movable at brim. No part of tumor is found in the pouch of Douglas. Sound enters towards the left and upwards, nearly 3 inches. *Per rectum.* Small body of uterus is distinctly felt apparently separate from the body of the tumor. On February 6th the patient was, after due preparation, submitted to operation. The room had been sprayed for some hours, and the usual antiseptic precautions were

employed, except the use of the spray during the operation. The abdomen was opened with ease. It was then found that the tumor was attached to the right broad ligament, and that there were considerable adhesions of its upper anterior part with the great omentum. Otherwise the tumor was free; the only considerable cyst in the tumor was tapped and about a pint of fluid run off. The edges of the tumor were now surrounded with sponges, and the tumor incised. The hand was then passed into the interior, the multitude of small cysts forming its mass were then broken up, and the contents squeezed out. In this way the tumor was lessened in bulk so as to pass through the abdominal wound, which originally measured about $3\frac{1}{2}$ inches. The omental adhesions were now fully exposed, and the attached part of the omentum was divided into a number of separate portions and tied by catgut ligatures. The pedicle was very broad and rather thin and short. It was transfixed and tied with silk ligature by the Staffordshire knot. As it seemed to ooze a little after being tied and the tumor separated from it, the loose ends of the thread were brought round the base of the pedicle and again tied. The sponges were now removed from the abdomen and the whole cavity thoroughly sponged out. The omentum was carefully inspected and no bleeding point discovered. The ligature was now cut short and the pedicle dropped. The abdominal wound was secured by deep and superficial sutures and the wound dressed with protective and salicylic wool and a flannel bandage. The patient was put to bed, surrounded by hot bottles, and a brandy enema administered. The operation lasted $1\frac{1}{4}$ hours. The solid weight of the tumor was 4 lbs. and the fluid above 12 lbs. The patient's recovery was excellent, though somewhat attended by persistent sickness and vomiting, which lasted for the first ten days after the operation, during which time she was fed by enemata. In the first few days the temperature ranged from 100 F. to 101.8, after that it became normal and remained so. Deep stitches removed on the seventh day, union complete. Patient improved daily after vomiting ceased, and was dismissed on March 10th, 1884, perfectly well.

Remarks.—Since the patient returned home I have heard that she continues to keep well. It is to be noted that the way the tumor was fixed

above by the omentum, and below by the pedicle, rendered its removal a little difficult. The fact, also, that its mass being made up of small cysts with thick contents did not permit of its bulk being materially lessened by tapping, I was obliged to incise it and break up its contents. Some anxiety was caused by finding that the fluid contents of some of the cysts, when subjected to microscopic examination by Dr. Foulis, were found to contain sarcomatous elements. This led to a special examination of the tumor, and the detection of sarcomatous thickening of certain portions of its walls. But, as there were no proliferating masses on any part of the surface of the tumor, we have the best reason to expect that the patient will do well, having escaped infection from the sarcoma.

CASE II.—M. P., æt. 21, no children, admitted December 18, 1883, complaining of pain in the right groin. Twelve months ago patient was suddenly seized one evening with a sharp pain in her right side; mustard was applied and relief was obtained for the time. From that time till now patient experienced at times a feeling of heat in the side. Menstruation natural. Health always good.

Condition on admission.—General appearance flabby and chlorotic. Abdomen distended to about the size of a seventh month pregnancy. The tumor is more developed towards the left than the right. Measurement round the most prominent part of tumor, about an inch below umbilicus, is $30\frac{1}{4}$ inches. From umbilicus to right anterior superior spine, $6\frac{1}{4}$ inches; to left anterior superior spine, $6\frac{1}{2}$ inches. Tumor feels smooth all over, appears to move with respiration. Percussion in right flanks clear, on left somewhat dull. Anteriorly over whole tumor is marked dullness. Fluctuation and fluid thrill are felt throughout the tumor. *Per vaginam.* Posterior part of pelvis and entire inlet are blocked by a tumor which moves in unison with abdominal tumor to a certain extent. The uterus is displaced to the left and upwards. Cervix uteri can be reached, but with some difficulty. Sound passes up and forwards without pain $2\frac{1}{4}$ inches.

Dr. Macdonald performed ovariectomy on Dec. 26, 1883. On entering the peritoneal cavity the omentum and a portion of the bowel were found adherent to a large cyst, which occupied the right

side of the abdomen. On the left side the same cyst was bare, the aspirator was passed, and about 90 oz. of a dark amber colored fluid drawn off. On attempting to remove the cyst it was found to pass deep down into the very base of the pelvis, so that it was impossible to complete the removal without 1. separating the bowel adhesion: 2. opening the broad ligament so as to get the cyst gradually enucleated from between its folds. In doing so some hemorrhage occurred, necessitating very numerous ligatures. The tumor, towards the uterine end, was firmly adherent to the broad ligament, so that the latter had to be partly included in the pedicle and partly torn into small pieces and tied. The pedicle proper was very thick and hard and short, and proceeded from the right upper angle of the uterus. On examining for the left ovary there was found protruding from the left broad ligament, in the site of the normal ovary, an elongate bowel-like cyst, with exceedingly thin walls, which occupied the left iliac and left lumbar regions. Over its anterior surface, and firmly adherent thereto, passed a considerable knuckle of intestine. As far as could be judged, the cyst bulged between the layers of the meso-colon. The bowel was firmly adherent to this cyst down to its pedicle proper, which proceeded from the left upper corner of the uterus in the same manner as the other cyst from the right. There was considerable difficulty and much bleeding during the separation of the bowel from this cyst, numerous ligatures being used. During process of separation of cyst it burst, and a large quantity of clear serous-looking fluid was squeezed out. Pedicle was now secured close to uterus, and its other adhesions tied in portions and divided. There was seen to be still some oozing from right side and floor of the pelvis, but no distinct bleeding points could be described. Abdominal wound was brought together in the usual fashion after the cavity had been well sponged out, wound dressed, a glass drainage-tube having been introduced into its lower angle. Patient put to bed with hot bottles, and a brandy enema given. The patient was much exhausted after the operation, and a second enema was given. On day of operation at 5 p.m. pulse was feeble, 130 per min. Dressing changed. There was squeezed from sponge and sucked from glass tube 5 oz. of sero-sanguineous fluid. An ounce of brandy ordered every 2 hours. 10 p.m.,

pulse stronger; temperature, 105.2. {Dec. 27th 10 a.m.: Wound looks healthy; 9 drachms sero-sanguineous fluid sucked from tube. Pulse firmer, ordered to diminish brandy by one-half. 5 p.m., Dressing changed; 8 drachms sucked from the tube. Temp. 100, pulse 139. One-ninth grain of morphia and $\frac{1}{16}$ gr. atropine given hypodermically. Dec. 28, 10 a.m.: Patient seems easier. 1 oz. sanguineous fluid got from tube and sponge. Temp. 99.2, pulse 128. 2 p.m.: Temp. 100.4, pulse 140. Dec. 29: Hypodermic of morphia and atropine given at 1.30 a.m. and 10.30 a.m. At latter hour discharge was septic and offensive. Dr. Macdonald washed out abdominal cavity with warm carbolic lotion 1-100. 3 p.m.: Temp. 100.8, pulse 150; another hypodermic given. 10 p.m.: Abdomen again washed out. 12 p.m.: Temp. 102.4. Dec. 30: Temp. gradually rose to 103, then 104 at 6.50, when patient died. No post mortem allowed.

Observations.—This case presents points of special and unexpected difficulty. Considering that there was no free fluctuation in the tumor and that the patient was a healthy woman, there appeared no ground to expect unusual operative difficulty, except in the fact mentioned in the case that the tumor projected deeply down on the right side of the uterus. It would almost appear that in this case we had to deal with two huge enlargements of the Fallopian tubes. At any rate, from the peculiar shape of the tumor on the left side, there is the best reason to regard this as most probably of tubal origin. The parts comprising the broad ligament were so disfigured by pressure of the cysts that it was impossible even with the most careful scrutiny, to detect any trace of ovaries or tubes to make certain that the cyst originated in the tubes. But the close connection of each pedicle the tumors possessed with the upper angle of the uterus seems to imply an origin from the tubes. I cannot help thinking that, notwithstanding the severity of the case, all might have gone well had she not had in the large wound some rather putrid pus. The drainage-tube seems to have been a source through which the putrid fluids were made septic. I need hardly say that we used every precaution in our power by protecting the end of the tube from the air to avoid this result. Be this as it may, it is evident that the patient died of septicæmia in spite of all efforts.

POLYPOID FIBROMA OF THE BLADDER.

BY J. FULTON, M.D., M.R.C.S., ENG., L.R.C.P., LON.

Prof. of Surgery Trinity Medical College, Toronto;
Surgeon to Toronto General Hospital, etc.

Primary neoplasms of the bladder are exceedingly rare, and when they occur attract no small degree of interest from a surgical point of view. Sir Henry Thompson in his work on the Urinary Organs (second edition) says: "Tumors proper to the bladder are of rare occurrence. Simple fibrous growths, chiefly in the form of polypi springing from the walls of the bladder and wholly unassociated with the prostate, are the rarest of all forms, known to me personally only in museums. Prof. Gross, of Philadelphia, in his admirable work on "The Urinary Organs" also states that polypoid fibroma is exceedingly uncommon, "excluding the cases recorded by Lusitanus, Kirchner, Sylvius, Rollin and other older authors, and those in which villous hypertrophy is a prominent feature of the growth, fifteen cases of fibrous polyp have been collected, of which eight occurred in males and seven in females, their ages varying from thirteen months to 56 years. In only six were the subjects impubic, the average age being the 20th year. The duration of the disease ranged from five weeks to three years, the average being fourteen weeks. Dr. Stein, of New York, in an excellent monograph on this subject states on the other hand, that polypi are more common in early life than any other kind of tumor. The subject of the present history was a male child aged one year and eight months, the youngest of a family of eleven; eight living and three dead. One died of inflammation of the bowels, another of croup, both under one year, and the third a little girl of five years of age was accidentally killed. The parents were perfectly healthy, and this child was healthy at birth, but at the age of three months he had some eruption of the scalp which the doctor called "scald head." This was soon relieved by treatment, after which he seemed perfectly healthy until some months afterwards when he appeared to be suffering from internal pain and swelling of the scrotum. The parents consulted the ordinary medical attendant, who thought the child was ruptured, and recommended them to obtain the advice of a neighbouring practitioner. Upon examination he diagnosed hydrocele and removed the fluid. This was about two weeks after the child first began to complain.

At this date there was no suspicion of anything being wrong with the bladder. The little patient seemed better for a short time after the removal of the fluid, but soon began to complain as before, especially when he attempted to urinate. The effort at micturition was attended with a good deal of straining and bearing down pain, and the child was constantly pulling at the prepuce. The parents again took the patient to the consulting surgeon and gave him an account of the symptoms. He immediately suspected stone of the bladder. He did not sound him at the time, however, as he had no suitable instrument, but told them to call back in a week or ten days. It was about two weeks before they returned, the symptoms evidently not being very urgent at that time. The surgeon administered chloroform, introduced the sound and examined carefully. He could detect no stone, but felt some thickening of the anterior wall of the bladder. Considerable hemorrhage followed the introduction of the sound. The child continued to strain very much in urinating, and now and again seemed threatened with retention of urine. A few days after the introduction of the sound, there was again some hemorrhage from the bladder; these were the only occurrences of hemorrhage. The amount of blood was not great—probably about half a teacupfull. The surgeon in charge then advised the parents to take the child to the Toronto General Hospital for treatment, and he was admitted under my care. At the time of his admission his mother stated that he had not passed any urine for nearly 24 hours. The abdomen was enlarged and felt quite hard as if the bladder was ready to burst. I introduced a catheter, but was astonished to find that only a small quantity of urine mixed with muco-pus escaped. On placing my hand over the abdomen it still felt quite hard, and there appeared to be a solid mass between the point of the catheter in the bladder and my hand, for which I could not account. On examination per rectum, I made certain that the instrument was in the bladder, and the posterior wall of that viscus felt quite normal. On the supposition that it might be an abscess in the abdominal wall, I ordered the child to be put to bed, to have a warm poultice applied, and a few drops of laudanum administered. This gave great relief. As might have been expected there was considerable febrile disturbance; skin hot and dry. The

bowels were kept freely open. On the following day the catheter had again to be introduced as the child was still unable to pass any urine. After drawing off the urine, which was small in quantity and mixed with pus, I introduced a very soft catheter with the view of leaving it in, but it was not long until the child, in one of its fits of straining which came on at intervals of a few minutes, forced it out with great violence. I then introduced a small silver catheter with a short beak and tied it in. Through this the urine escaped for the next two or three days. In the meantime there was no amelioration of the symptoms—the child was evidently growing rapidly worse. I had held out no hopes of the child's recovery to the mother from the first. Fearing that the catheter might increase the irritation I removed it, and drew off the urine as required by means of a gum-elastic catheter. Although somewhat puzzled at first in regard to the diagnosis, I had now come to the conclusion from a close scrutiny of the history, that it was a case of polypoid fibroma of the bladder. I stated my conclusions to several of my confrères, but they seemed incredulous. Some thought it was a perineal abscess, and advised me to make an incision. This opinion was, in some measure, justified by the fact that the urethra was enlarged, and pus from the bladder escaped through it during the last day or two of the child's illness, but as I had watched the case closely and examined the parts carefully, I felt certain there was no abscess. The passage of a small polypus about this time verified my diagnosis. The child died on the 11th day from the date of admission, and a *post mortem* examination revealed the true nature of the case. The bladder was completely filled to distension with polypoid growths which sprang from a pedicle about an inch in width and a quarter of an inch in thickness, and was attached to the left anterior wall of the bladder. The coats of the bladder were thickened except at the summit, which had ultimately given way by ulceration. Urine and pus escaped into the abdominal cavity and brought on fatal collapse. The ureters and pelves of the kidneys were very much dilated, and the kidneys more or less congested. The urethra and neck of the bladder were also dilated. The polypoid growths which were globular in shape, smooth and even, have shrunk very much since placing the specimen in alcohol. Under the microscope the tissue appears lax and

succulent, and made up of delicate interlacing filamentous tissue. It is not very vascular, and is covered with a reflection of the mucous membrane, the cells of which are normal. Prof. Gross tells us in his admirable work above referred to that "these tumors occasionally co-exist with urinary calculus, or they may be encrusted with crystals of triple phosphates, and that they evince a remarkable predilection for the neck of the bladder."

The symptoms of polypoid fibroma are chiefly of a mechanical character, viz. : difficulty in micturition, sudden stoppage of the flow, painful retention accompanied with great straining, requiring the frequent use of the catheter. The occasional passage of a small polypus as in the present instance, will at once establish the diagnosis. There is usually very slight hemorrhage, which may only be occasioned by the introduction of instruments. There is frequently pain at the head of the penis as in stone of the bladder. In females a protrusion of the tumor from the urethra is a valuable symptom. In this connection a most interesting case was published by Mr. Stanley in the *Medical Times and Gazette* of 1852 (page 106) in which, from continued retention of urine, some of it was forced into the imperfectly closed urachus which gradually reopened until the urine reached the umbilicus and escaped. The patient was a male child 13 months old.

The differential diagnosis of polypoid fibroma may be made by having regard to the train of symptoms just stated. It occurs at an earlier age than papillary fibroma, and unlike it, bleeding is not a frequent sign, and when it does occur is only trifling in extent. It may be diagnosed from carcinoma of the bladder, from the fact that the latter is rarely primary, and is attended with the cancerous cachexia—from calculus of the bladder by the introduction of the sound. From hypertrophy of the prostate by the introduction of the finger in the rectum. The prognosis of this affection is most unfavorable as when it is not removed by surgical procedure, a fatal issue invariably occurs from retention of urine and its effects upon the kidneys.

The treatment of tumors of the bladder is palliative and radical. The former consists in administering remedies to allay pain and spasm, the use of the catheter when required and the arrest of hemorrhage when it occurs. Among the earlier operators in these affections was Civiale. He en-

deavoured to remove them by avulsion and the use of the lithotrite; but his success was not very encouraging. Cystotomy is the only rational method of treating these growths. They may be removed by avulsion, enucleation, ecraseur, or ligation. The fact that the operation has been several times successfully performed should encourage us in its performance whenever suitable cases present themselves. Billroth, after having first verified his diagnosis by opening the bladder through the perineum, divided the recti muscles at their insertion, opened the bladder transversely, and removed the tumor by avulsion. The patient was discharged cured on the 23rd day. Dr. Mass, of Breslau, in 1876, suggested a plan which it would be well to have recourse to before subjecting the patient to a cutting operation. It consisted in pouring water into a double current catheter (with a large eye) inserted in the bladder, in the hope that the out-flow may entangle the growth in the eye of the instrument. In this way he succeeded in three cases in removing small pedunculated mucous polypi. The lithotrite might also be used to remove portions of the growth for examination. In females the short and easily dilated urethra and absence of the prostate renders access to the tumour tolerably easy of accomplishment and the risk is much less; not unfrequently also the tumor protrudes through the urethra and may be ligated or pulled well down and removed by avulsion. In the case before us, from the nature of the growth and its attachment, an operation would, in all probability, have been attended with success if the diagnosis had been made with certainty sufficiently early, *i. e.*, before the disease had progressed to the stage of ulceration of the bladder. In any similar case occurring under my care in future I should have no hesitation in performing cystotomy with a view to the removal of the growth. The operation has met with a large measure of success in the hands of Sir Henry Thompson and others.

SURGERY OF THE SPINAL CORD.*

BY J. CAMPBELL, M.D., L.R.C.P. ED., SEAFORTH, ONT.

The very interesting and important subject of what now generally goes by the name of "Railway Spine," has, during the last year, been attracting

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renewed interest. This has been owing in a great measure to the publication of Page's work "On the Injuries of the Spine and Spinal Cord." Mr. Page has been for a number of years surgeon to one of the greatest railway corporations in England, and, therefore, had a very extended experience of all possible railway injuries, and particularly of cases of so-called "Railway Spine." He contends that cases of what are commonly called "concussion of the spine," do not exist, except in the imagination of the surgeon making the diagnosis. By concussion he means the cord receiving an injury of such a nature as to give rise to pronounced symptoms, without, at the same time, the vertebræ, ligaments or membranes receiving any hurt.

It is well-known that Mr. Erichsen has been a strenuous advocate of the theory that the great majority of cases of railway injuries having for their symptoms, spinal symptoms, are due to concussion of the spinal cord. The first one hundred pages of Mr. Page's book are taken up with combating this view of Erichsen, and it appears to me that Mr. Page's attempt has been successful. He, at least, conclusively shows that the vast majority of cases of concussion of the spine are nothing more nor less than cases where the lumbar muscles or ligaments of the spine have been sprained or ruptured. Erichsen contends that many cases of "concussion of the spine" received in railway accidents never recover, while Page, on the other hand, maintains that these so-called cases of spinal concussion always do recover. While representing the reaction, Mr. Page's recent work certainly favors an undue belief in the certainty of recovery in cases of this sort.

Erb presents the matter more fairly than either of these writers. Accidents which occur in railway collisions, as other accidents, may lead to a long train of nervous symptoms, and when death has resulted, a post mortem examination may show little apparent cause for the fatal result. In the greater number of these cases the pathology is a riddle, which, for its satisfactory solution, will need a great deal of experiment and careful and extensive post mortem investigation. The great trouble in coming to an opinion as to the nature and cause of a train of nervous symptoms following a railway injury is not whether we have to do with a functional or organic change, but whether we have to do with an actual or feigned train of

symptoms. Usually the patient's symptoms are of such a nature that the physician can come to a conclusion without much trouble, but where he has to do with an intelligent and unscrupulous man who expects a large sum from a railway company, the case is one of extreme difficulty. In many of these cases it is quite impossible to come to a certain diagnosis.

In the words of a recent writer, the "needed clinical work, it seems to us, in the study of 'railway spine' is the determination of clearly defined types of the disease, and the investigations of the variations from this type, and the certain relation of objective symptoms to the disease." That serious and even fatal effects may arise from changes in the cord where it has not received any direct injury has been abundantly proved. In the current number of one of our periodicals there is a very instructive case reported, by Dr. Edmunds, of a soldier who was struck in the back with a bullet. He fell immediately, and had to be carried out of action. The bullet entered the back two or three inches from the spine, and the surgeon who first attended him considered that the spine was severely injured, because the patient had lost complete control over both lower extremities. Patient had paralysis of the bladder and rectum also. There was cystitis and a bed sore over the sacrum before death, which occurred five months after the injury. At the autopsy there was no fracture or indication of fracture, or dislocation of the vertebræ to be found. The cord was seen to be much atrophied and softened about the level of the wound. On hardening the cord in Müller's fluid, it was seen that there was universal myelitis and softening for about two inches opposite the wound, this gradually passing below into sclerosis of the lateral and anterior pyramidal tracts, and above into sclerosis of the posterior columns. There was no indication of hemorrhage, either external or into the substance of the cord. Its surface was uninjured. This was undoubtedly a case of pure "spinal concussion." The immediate paraplegia following the injury could not have been due to any other cause. The case is then one of very great importance, as it proves most conclusively that we can have from a severe shock sufficient changes brought about in the spinal cord to cause death, and that these changes were in the first place nothing more or less than "concussion of the spine."

Very recently the opinion appears to be gaining ground that we may have tabes dorsalis arise from peripheral causes. That, in fact, an ulcer in the foot may be the *fons et origo mali* of this formidable disease. The origin of the disease in such cases is explained by first a peripheral neuritis gradually extending along the course of the nerves until it reaches the posterior roots, and there a similar process gives rise to a subsequent sclerosis of the posterior columns.

SURGICAL DISEASES OF JOINTS.

BY H. P. YEOMANS, M.D., MT. FOREST.

Report on Surgery, Ont. Med. Association.

In cases of very great distension with continued pain in the later stages of acute or subacute synovitis, Barwell recommends puncture and withdrawal of the fluid. This is accomplished with a sharp small tubular needle, having a rubber tube attached. Pressure is made by an elastic bandage around the knee so as to press out the fluid and prevent the entrance of air. The rubber tube may be filled with a solution of carbolic acid and held above the joint until the puncture is made. After the needle has entered the cavity containing the fluid, the tube may be lowered and its free open end placed in a carbolic solution. By this means tension is relieved, and consequently pain; means must afterwards be adopted to lessen inflammation such as cold, or in some cases heat, etc.

Suppurative synovitis may, after evacuation, be treated by complete rest and thorough drainage. The temperature falls or rises as the pus is retained or thoroughly washed out.

In hip-joint disease rectal examination has been employed in addition to other methods of diagnosis. The symptoms discovered by a rectal examination are pain on pressure upon the os-innominatum behind the acetabulum—enlargement of the intra-pelvic glands, thickening of the bones, depression, flexibility, mobility, or destruction of the post-cotyloidean surface, congestion of the soft parts pelvic abscess—one or other of these symptoms may be found in different stages of the disease.

With regard to treatment, Dr. Hutchinson deprecates the application of any retentive apparatus whatever. The patient wears a high heeled shoe on the sound limb, is provided with a pair of crutches and allowed to go about. He points out

“that immobility is secured by reflex contraction of the peri-articular muscles, aided by intracapsular effusion and the voluntary effort to keep the joint at rest on account of the pain which motion produces.”

Splints of all kinds allow more or less mobility of the joint and interfere with freedom of the patient in moving about in order to obtain necessary exercise. There appears to be considerable difference of opinion as to the efficiency of all the various appliances and methods of treatment.

Reports of Societies.

MICHIGAN STATE BOARD OF HEALTH.

(Reported for THE CANADA LANCET).

The annual meeting of the Michigan State Board of Health was held in Lansing, Mich., April 14, 1885. All the members were present. The president's address was the first order of business. He congratulated the Board on what it had achieved. He thought it would be well to continue holding sanitary conventions in different places in the State. He spoke of the probable advent of Asiatic cholera, and thought that it might tax the Board to its utmost. The Board had done all it could to prepare to resist the disease, but should be ready for further action. If the bill before the legislature becomes law, the powers of the Board will be increased. He advised police regulations in cities, to prevent unsanitary conditions; and said that health officers of cities, villages and townships, especially those recently appointed to that office, should be instructed in regard to their duties.

The Secretary read a report of the work of the office during the past quarter. Ten thousand copies of the document on the restriction and prevention of contagious diseases were distributed. The Secretary also stated that the outbreak of smallpox at South Boardman had been suppressed.

At the last meeting of the Board, the subject of proposed legislation relative to diseased animals, and also relative to a standard for milk, had been referred to a committee, and bills relating to those subjects had been introduced into the House of Representatives.

The Secretary reported that there had been considerable effort to get the legislature to lower the

standard test for dangerous oils, and to do away with the use of the tester adopted and recommended by this Board. It was claimed that the changes were needed in the interests of small manufacturers. The proposed change would lower the standard about ten degrees. A resolution was passed deprecating the lowering of the test now required for illuminating oils.

The Secretary read the report by Surgeon Geo. M. Sternberg, U.S.A., now at John Hopkins University, on his experiments on lower animals in feeding, and in making injections of culture-fluids of poisonous cheese, with the view of learning the nature and source of the poison.

Dr. Vaughan gave a report of his experiments with poisonous cheese. He had secured in a crystalline form a substance from poisonous cheese which would produce in man symptoms common to cheese poisoning. There might be other poisons in poisonous cheese. He had not yet fully studied the poison he had obtained. It gave reactions like those of a ptomaine.

The Board recommended a sanitary survey of the cities and villages in the State, and the adoption of such measures as may be necessary to place them in a good sanitary condition.

Selected Articles.

FORTY YEARS' EXPERIENCE IN MIDWIFERY.*

BY W. SYMINGTON BROWN, M.D., OF STONEHAM, MASS.

The art of midwifery belongs to prehistoric times; the science of obstetrics is the latest recognized of all the ancient sciences. There is no branch of medicine which demands more skill, presence of mind, or justifiable daring than midwifery. It needs a man who can neither be overwhelmed by disaster nor unduly elated by success,—one who has the courage and honesty to do whatever is best for his patient, irrespective of consequences. Of such men no profession possesses a superfluity.

It is a strange fact, however, that only sixty years ago practitioners in midwifery were not admitted as Fellows to the College of Physicians, London, on the ground of inferiority, and the Royal College of Surgeons did not require candidates for its diploma to undergo an examination in obstetrics. This odium has nearly disappeared in our day, but

a single item illustrative of its vestiges may be cited. I refer to the fact that the popular encyclopædias of our own day make no reference to the lives of prominent obstetricians, such as Smellie, Levret, or Naegele. Hundreds of insignificant names are recorded in Appleton's, Chamber's and Johnson's Encyclopædias, but a profound genius like William Smellie—writer, teacher, inventor and artist—is not even mentioned.

During a short visit to Scotland, in 1878, I met a lady, thirty-five years old, at whose birth I officiated obstetrically. And I had attended more than a hundred midwifery cases before that one. I wish I possessed a record of them all. While a medical student I served three years as assistant to the late Dr. James Paterson, Professor of Midwifery in the Andersonian University, and delivered many women among the destitute poor of Glasgow. During the last nineteen years I have kept a moderately full record. The whole number, dating from 1840, must exceed 2,000 cases.

In 1842 forceps were rarely used. It was a period of reaction, and many physicians entertained a strong prejudice against their employment, except in extreme cases. Dr. F. H. Ramsbotham, physician to the Royal Maternity Charity, London, in summing up the symptoms warranting recourse to forceps says: "If the pains have entirely disappeared, if the strength is failing, the spirits sinking, the countenance becoming anxious, if the pulse be 120 or 140 in the minute, the tongue dry, brown, and raspy; if there have been two or three rigors; if there be green discharge; if the head have been locked for four hours, and made no progress for six or eight hours; if the patient be vomiting a dark, coffee-ground-like matter; if there be hurried breathing, delirium, or coldness of the extremities." *then* we may use the forceps—before sending for the undertaker.

I recollect attending one case in Glasgow during a long-drawn-out week. The woman was very poor, and had been compelled during the whole period of gestation to sit from fifteen to eighteen hours a day, winding pirns, in order to earn a bare subsistence. There were no alarming symptoms, but the abdominal muscles seemed to be powerless. I sent for Dr. Paterson, and requested him to help her flagging powers with the forceps, but he declined to do so. The case did not come under any of Ramsbotham's excuses. At last the poor woman got tired of waiting; she sent for a doctor with fewer scruples and was instrumentally delivered. This case made a deep impression on my mind, and, in fact converted me to the faith which I hold to-day.

In this paper I propose to state very briefly the principal conclusions I have arrived at under six heads, namely: Forceps, Turning, Ergot, Anæsthetics, Antiseptics, and Craniotomy. Before doing so, however, allow me to make one remark in regard to

* Read before the Obstetrical Section of the Suffolk District Medical Society, January 21, 1885.

the language employed. Although what follows may appear like laying down the law in a somewhat curt fashion, such is not my intention. What follows are simply my own opinions on certain obstetrical problems colored by the personal medium. Nobody is more anxious than I am to be set right where I have been wrong. The late Dr. J. C. Warren, in his classical work on "Tumors," gives us this good advice: "He (the surgeon) must get the opinion of other surgeons. Even those who have not so much experience as himself may afford him excellent hints, and strike out from his own mind thoughts which without this collision would not have been elicited." Dr. Barnes also truly asserts that "there is no man whose experience is so great that nothing is left for him to learn from the experience of others." Such societies as this one answer that purpose.

FORCEPS.

I prefer curved to straight forceps. They are about as easily applied, and are less liable to slip. If a beginner can only afford one it should be a long pair, either nickel or silver-plated. But it is convenient to own a short pair, and I always carry one in my obstetrical bag, along with a No. 6 gum-elastic catheter (male), a Davidson syringe, a hypodermic syringe, a few feet of flat covered wire (such as milliners use), ether, ergot, chloral and whiskey.

The short forceps may be used at any time when their employment will benefit the patient or her coming child. We should *not* use them merely to save our own time. But the long forceps (when applied within the uterus) should seldom or never be used without a consultation. Indeed, it is a wise precaution, in most difficult or dangerous cases, to call in a brother practitioner to share the responsibility. I make it an invariable rule to pass a soft catheter into the bladder before applying forceps. In some cases using the catheter helps progress, even when forceps are not needed. If the rectum contains solid fæces I also give an enema of warm soapsuds.

How should the forceps be applied? In Scotland the woman is placed on her left side, with her hips projecting from the bed. In this country the dorsal position is preferred, and it is the one I most frequently use. Lately I have tried a new way, which has certain advantages. The woman lies on her back in the centre of the bed or anywhere, and is not moved at all. Of course, it is not convenient to use long forceps in this position; but, when practicable it avoids the appearance of preparing for a surgical operation, and I think the less fuss we make the better it is for our patient.

In most cases I insert each blade at the side of the pelvis, without regard to the position of the child's head. If the vertex presents, you can scarcely go wrong by following this rule, and it

saves the patient the annoyance of searching for an ear and other annoying manipulations. I make traction only during a pain, and relax pressure when the pain abates. I think it is advisable to pull with a slight pendulum motion, instead of using direct traction, on the same principle that it is easier to pull down a pair of tight pantaloons by drawing on alternate sides than by pulling on both sides at once.

ERGOT.

As a means of shortening labor, ergot is seldom employed nowadays. The forceps have crowded it out of use for that purpose. But as an agent in promoting uterine contraction, after delivery of the placenta, and especially in cases of threatened flooding (some women have a hæmorrhagic idiosyncrasy), it is a valuable remedy. One reason why ergot has fallen into disrepute is the poor quality of many specimens offered for sale. Dr. Squibb's aqueous extract rarely disappoints me. It should be borne in mind, however, that no drug is readily absorbed during extreme depression.

After much blood has been lost our main reliance should be placed on other agencies, such as injections of very hot water and mechanical pressure. The accoucheur's hand inside the womb, with external counter-pressure, is the most reliable method. In milder cases I have succeeded in arresting severe hæmorrhage by injecting hot water and vinegar into the flaccid uterus. But the water must have a temperature of 130° F. in the basin, as it cools during its passage along the tube.

TURNING.

As this operation requires no surgical instrument, it obviously antedates the forceps, and, since the days of Ambrose Paré, has been a favorite with many practitioners, and even with skilled midwives. I was acquainted with a physician who, if one might draw an inference from his usual practice, seemed to think that nature had made a mistake in placing the child upside down in the womb. In our own day the late Sir James Simpson, Dr. Barnes, and Dr. Braxton Hicks have done much to bring version into favorable notice. On one occasion, before labor had fairly commenced, while making an external examination, I detected the child's head above the brim, and succeeded in converting a cross presentation into a normal one by the Braxton-Hicks method. I was agreeably surprised at the ease with which the change was effected. But, notwithstanding the plausible arguments advanced by Simpson, Barnes and others, I have come to the conclusion that turning, after the evacuation of the liquor amnii, is a very dangerous operation for the child, and not much safer for the mother. I admit that cases occur where no other alternative (except Cæsarean section) is left us. If we conclude to turn, the operator's left hand should be used, and, in most cases, it is better to bring down one foot than

two feet. The accoucheur's left hand is the obstetrical hand *par excellence*. Physicians should learn to use it adroitly more than they do.

ANÆSTHETICS.

The foremost question under this head is, Do anæsthetics injure the patient? I am pretty sure that they do not. Since 1849 I have used ether, chloroform, or a mixture of the two with alcohol, in every case where the woman was willing to breathe an anæsthetic. Some object; they are afraid to take it, and these I do not urge; but the majority are glad to get it before the labor is over. As a general rule I do not give ether during the first stage.

High authorities tell us that there is a greater tendency to post-partum hæmorrhage after ether or chloroform has been administered. During the last sixteen years I have not employed chloroform in midwifery practice, except as a remedy for convulsions; but I believe that ether, in moderate doses, does not tend to bring on flooding. Ether is seldom given to the extent of unconsciousness. The patient knows what is going on, and can render voluntary assistance when solicited.

A small dose of ether acts beneficially in two ways: it blunts sensibility to pain and allows the abdominal muscles to aid in propulson. Without ether the patient's will-power is instinctively exerted to delay the labor; with it the canal is more likely to be relaxed, and the voluntary muscles are not so much restrained. The contractile power of the womb itself is not affected by moderate inhalation of ether.

ANTISEPTICS.

Cleanliness is a good thing in midwifery, and antiseptics are its aides-de-camp. A young doctor who keeps his nails in mourning will eventually have to mourn the absence of a lucrative practice. Still it is possible to have too much of a good thing. Dr. Thomas, of New York, has recently taken a stand on this subject which most physicians would call ultra. The rules and regulations he lays down might possibly be enforced in a hospital, but hardly in private practice. And even if they could be carried out, I question the advantages of trying to surround a physiological process with all the paraphernalia needed in a surgical operation. Carbolic acid has had its flood-tide, and begins to ebb. Corrosive sublimate will probably follow suit at no distant day. Please observe, I do not object to disinfectants or antiseptics in themselves. Both of the chemicals mentioned will no doubt, be used occasionally with advantage. But I believe that carbolic acid nearly killed Dr. Thomas Keith, and not a few unfortunate patients have suffered from its wholesale reckless employment. I greatly prefer a weak solution of iodine, prepared with iodide of potassium, which may be diluted with water without precipitation, or a hot

solution of permanganate of potas. In ordinary cases absolute cleanliness is all that is needed. The routine employment of vaginal injections is likely to do more harm than good. I concur in the opinions expressed by Dr. Adams, of Framingham, in his interesting paper read at your last meeting. Dr. William Godell's suggestion that lying-in women should be encouraged to assume the erect posture early, with a view to facilitate the removal of clots and *débris*, is an excellent one.

As already hinted, it is a good plan for the obstetrician to wash his hands, keep his finger nails pared pretty close, and to fill the small remaining space with softened soap before making a vaginal examination. A Syracuse æsthetic M.D. kindly suggests that no harm would result if he also washed his hands afterward.

CRANIOTOMY.

During the last nineteen years I have performed craniotomy three times, all of the cases occurring in the practice of other physicians. No operation tries a surgeon's nerve more than this one. When we are sure that the child is dead, of course it is plain sailing. But there are cases when the foetal heart cannot be distinctly heard, and yet the child is alive. To plunge a perforator into a living child's skull, and deliberately take its life, with the view to save that of its mother, is, to say the least, a sad alternative. I hope I shall never feel compelled to do it again. In these days of successful abdominal surgery, would we not be justified in appealing to the patient to allow us to perform the Cæsarean section or laparo-œlytrotomy? But we should not wait till the woman is at death's door before operating. In this, as in all other life-saving operations, promptness and decision win the day.

The medical profession is deeply indebted to Dr. Thomas for his efforts to popularize laparo-œlytrotomy. I understand that he tried the operation several times on the cadaver before performing it on a patient. Nearly all great surgeons have been in the habit of doing this. In this case the principal difficulty will be to get the consent of the patient and her friends in season to be of any service. We all love to put off the evil day, or even the evil hour, and so the golden opportunity slips through our fingers. But as successful results in this line increase the dread of the operation itself will decrease, and obstetric surgery may achieve a new triumph in the salvation of human life.—*Boston Med. & Surg. Journal.*

SUGGESTIONS FROM DISPENSARY EXPERIENCE, FOR THE SURGERY OF GENERAL PRACTICE.

BY DR. C. W. DULLES, PHILADELPHIA.

It has often seemed to me that the experience gained in the many dispensaries of our large cities

is not made of as much service to the profession as it might be, and that it would not be amiss if those who have the advantages which these positions afford would occasionally try to put into accessible shape the lessons which they have there learned, and lay them before their brethren for adoption or correction. And, because I have had to learn by experience some things which it would have been better for my patients if I had found out in some other way, I have thought it might be worth while for me to invite your attention to certain notions in regard to the kind of surgery which occurs in general practice, which I have gathered during the past ten years, and which, if they are correct, may be helpful to others; if they are incorrect, I shall be glad to have them criticised.

I. THE DIAGNOSIS OF SURGICAL LESIONS.

I trust I shall not be deemed officious in urging the importance of thoroughness and discernment in making up a diagnosis as to what is the nature of the lesion for which one is consulted by a sufferer. Every writer, and every lecturer, dwells, more or less, upon this point. But, in spite of all that is said and written, mistakes are constantly being made, which greater care would have prevented. I have seen fractures treated as contusions, and contusions as fractures, over and over again. I have seen a patient treated for a fracture at the lower end of the radius with a time-honored Bond's splint, who had nothing the matter near the wrist, but who had a severe and dangerous contusion of the elbow-joint. I have seen hydroceles treated for years as herniæ, and have been called to operate for strangulated inguinal hernia when there was only a hydrocele of the cord, innocent and easy to cure. I have seen a psoas abscess mistaken for a hernia, and over and over again sinuses of the face, due to disease of the root of a tooth, treated in vain as simple abscesses, the recognition of the cause and the removal of the offending tooth being followed by a prompt recovery. I do not care to cite many mistakes of my own, but I cannot forget my mortification once when caught napping by an ulcerated knee, the syphilitic nature of which was indicated and easily demonstrated when a more experienced surgeon asked to see the other leg. On the other hand, I have known lesions to be characterized as syphilitic on what I thought to be an unwarrantable suspicion, and a cross-examination to show that what a patient called a chancre could not possibly have been the initial lesion of syphilis. Now, such errors should not be passed over, or hushed up, when we are speaking among ourselves, or we shall miss the advantage of being taught the necessity for constant vigilance and thoroughness in examining our patients. Of course, this is not the place to discuss the diagnosis of various lesions; but it may be worth while to call attention to the importance of making our

examination include, not only the part believed by the patient to be injured, but also the surrounding parts—muscles, bones or joints, as the case may be—for some distance above and below. The opposite and corresponding parts should often be looked at, for purposes of detection or comparison. Nor should we hesitate to call to our aid the probe or the exploring needle, both of which are valuable and harmless instruments in judicious hands. Two little points, in regard to the sinuses of the face, I would like to speak of. One is the well enough advocated examination of the teeth, by inspection and tapping, to detect a state of abscess in the alveolus; the other I do not remember to have seen recommended. This is, to test a suspected salivary fistula by bringing a drop of the discharge into contact with a drop of the tincture of chloride of iron on a white surface—a piece of white paper will do—when, if the discharge contain saliva, it will give the pink color which indicates the presence of the sulphocyanide of potassium, a normal ingredient of saliva. And, before dismissing this subject, I think a word may be said as to the failure, when one is really at a loss, to get the opinion of some one who is more familiar with our subject than we are. However proper the motives may appear which lead to this, they cannot avert from the patient the consequences of error or delay in diagnosis or treatment; and I believe it would be greatly to the advantage of our patient and ourselves, if we accustomed them to the idea of having a consultation before a case becomes extreme.

2. THE CLEANSING OF WOUNDS.

My own experience has led me to the belief that this salutary proceeding is sometimes overdone. When we see a scalp-wound, or a laceration of the face, covered with a scab, even though it be not a very handsome one, good surgery does not, I think, require us to take it off, unless the appearance of the neighboring parts indicates that an inflammatory process is going on under it. Nor, when a crushed finger is enveloped in dry covering of blood and machinery grime, need we think our patient's safety depends upon a thorough removal of these. On the contrary, I should say his rapid recovery often depends upon our letting them alone. But scabs that cover pus may always be removed with advantage; and foul secretions, or accumulations, can only do harm, and must be cleaned out. So the cleansing of wounds is not only an æsthetic, but also a salutary, procedure. As to the method of cleansing, I am a convert to the views of Mr. Sampson Gamgee, who never uses a liquid for cleansing when it is not specially indicated. Careful mopping with dry cotton or lint will do far more than those who have not tried it would imagine. Rubbing is rarely called for, but just touching with the cotton or lint, and pressing it down with more or less firmness, as the circumstances require. But, when the case demands it,

we must not hesitate to rub firmly, even a little roughly, or to pick off or cut off what sticks tight to the healthy tissues. However, we should not eschew the use of water too tenaciously. It is often indispensable, and, combined with a little permanganate of potash—just enough to make a transparent, pink solution—it is a *sine qua non* in dispensary practice, as a disinfectant and deodorant. This combination, it seems to me, excels every other so-called antiseptic; and carbolic acid, I may say, I never use as an antiseptic at all. In this connection, I wish to emphasize what I think is a very important matter in washing of wounds and sores, namely, that the same fluid should never be used twice; that is, it should not be dipped from a basin and allowed to flow from the wound or sore into the same vessel, and then dipped up and used again, and so on. The best way of washing a wound would be to let the water run upon it from a hose with a regulated force. But almost, if not quite, as good as this, is the plan of having one vessel to hold the wash and another to catch the drippings, and to apply the wash by letting it fall in a steady stream from a clean sponge or a mass of oakum. The size of this stream, and its force, can be easily regulated by the force with which the sponge or oakum is squeezed, and the height at which it is held. If the dripping mass be grasped in the hand and held with the thumb up, by well-regulated squeezing a single stream can be made to fall from the dependent portion in exactly the place and way we wish.

3. THE CONTROL OF HEMORRHAGE.

An important part of the preparation of a wound for dressing, is the control of hemorrhage—I do not mean the hemorrhage from large vessels, but that from small ones, such as are usually encountered in the surgery of general practitioners. Our colleague, Dr. Roberts, has, I think wisely, deprecated the routine use of styptics, and I quite agree with him that, for almost all small vessels, the pressure of a well-applied dressing will do all that is needed in the way of controlling hemorrhage. Such a dressing may be made of dry lint, bound on with moderate firmness—actual tightness is not called for—and often one will have, in a little while, an imitation of nature's favorite method of healing, by the formation of a scab, made up of dried blood and the tissue of the dressing. The essentials for controlling moderate hemorrhage are dry dressings and moderate compression. Pressure alone is sufficient to control the bleeding from scalp-wounds, which are sometimes spoken of as if they were troublesome to deal with. It is remarkable, at times, to hear men describe the pains they have been at to ligate an artery of the scalp, in view of the fact that this is never indispensable. A compress and a bandage will control any vessel in the scalp, and almost anywhere else; and, if an unruly patient is likely to pull a bandage off, a pin,

even a common one, may be thrust under the vessel and brought out again beyond it, so as to hold it as long as any one could wish. If still greater security be desired, it can be had by adding a "figure 8" to this pin. And here I wish to add a word as to the need for stopping bleeding. I will go a little further than Dr. Roberts in regard to the innocence of hemorrhages which sometimes cause great uneasiness. Many of these hemorrhages are absolutely beneficial. Of course, one need not be foolhardy; but such hemorrhages as come from superficial wounds may be regarded with the greatest equanimity, and no one need get flustered in trying to stop them. In my own experience, I often encourage bleeding to a considerable extent, as in the case of incisions for felons and palmar abscesses, and the like, and have never felt that I lost anything by being deliberate. Hemorrhage from small vessels can often be controlled by a firm pinch with the forceps, or the vessel may be drawn out and twisted round several times. This will often obviate the necessity for ligatures, in operations such as circumcision of infants or children. Sometimes the arteries in the fingers will bleed in a most troublesome way. If the bleeding cannot be stopped by pressure or torsion, it can be controlled by a pad of lint and a few circular turns of adhesive plaster. Persistent hemorrhage from an alveolus, in one with a hemorrhage diathesis, I have controlled, when plugging gave only temporary relief, by injecting a fine stream of cool water against the bleeding point. Bleeding from the wound of the palmar arch can, I believe, almost always be controlled by a pad and bandage.

4. DRESSING OF WOUNDS.

Dry Dressing.—Nature's method of protecting wounds is by the process of scabbing; and when we reflect upon the successful way in which this operates in all the lower animals, and often in man, too, we may wonder that it should be almost a matter of routine to remove scabs in surgical practice. It may gratify our curiosity, it may even aid our study at times, but it is often of no advantage to the patient to remove from a disfigured face, or a cut head, the crusts which are nature's reliable antiseptic dressings. From what I have seen, I believe it is best to leave such crusts undisturbed whenever possible, and if they are objectionable, in an æsthetic sense, simply to cover them with something better looking. Further, it may be said that an artificial scab made with lint, or tarlatan, or thin muslin, and collodion, forms one of the best dressings for simple incised and not a few lacerated wounds, which have ever been devised. In hospital practice, I see many cut heads and simple incised wounds, even after the removal of tumors, which go to a prompt and uninterrupted healing under the first dressing of this sort. Similarly, scabs may be formed by allowing lint to become saturated with the oozing of a wound exposed to

the air. Dry powders, such as earth or bismuth, or calomel, or powdered borax, or boric acid, or iodoform, may also be used to promote the formation of a crust. In all these cases, however, it is important to watch lest the crust bind down offensive discharges, as any scab may do; when this happens, the crust must, of course, be removed, and the wound cleaned. In the case of strumous ulcers and the weak granulations of large burns, I have had the happiest results from setting aside ordinary dressings, and applying a powder in this way. In these latter cases, I have sometimes practiced exposure of the granulating surface to the air until the serous film covering them has coagulated and formed a species of skin over them. And to my astonishment, I have seen such a film actually transformed into thin skin without displacement. This is a fact which I believe does not accord with the accepted laboratory idea of new skin formation; but it is a fact, nevertheless. And I would especially urge upon others this plan of treatment in the class of cases referred to—old burns and strumous ulcers—which are, I believe, often kept open by the ointments and other warm and moist dressings used to promote their healing.

Water Dressing is another good dressing, which I believe is too little appreciated. I have seen a number of wounds of the fingers and hands, for example, done by machinery, in which rapid and painless recovery has followed the application of wet lint, which was wetted again as often as convenient, with a lukewarm or cool solution of common borax. Patients with such injuries I have often dressed with cold water, and told them to dip the finger or hand, as the case might be, in a solution of a teaspoonful of powdered borax in a pint of water, warm or cool, as they found more pleasant, without removing the first dressing.

Lead-water and Laudanum is but little better than cold water, so far as my experience would indicate; although it is suited to cases that are especially hot and painful. But I believe this ought never to be covered up, as it very often is, with impervious coverings. It is not an uncommon thing for me to see a cut hand, or a contused joint, or a painful fracture, covered with lint soaked in lead-water and laudanum, with a piece of waxed paper over this, and next a bunch of oakum, the whole bound to a splint with many layers of bandage. My inquiries have usually elicited, from patients treated in this way, the most expressive assurances that they had suffered much, often having passed a sleepless night after these dressings were applied; and I have, I think I may say invariably, found that the suffering disappeared when I changed the dressing for a light lint, dipped in lead-water and laudanum, and held in place by a thin, light bandage, so applied as to leave part of the lint exposed to the air and consequently to evaporation of the lotion, with no splint at all, or

the lightest and smallest kind possible. What makes a recent injury hot and air-proof, I have found usually a painful dressing.

Dilute Alcohol is another refreshing dressing, if it be allowed to evaporate, and removed at the first sign of pain.

Carbolized Oil, which is, perhaps, not such a very common surgical dressing nowadays, I have found to become very quickly offensive, and I now hardly ever use it. If renewed often enough, it is, however, soothing and healing.

Ointments.—To discuss fully the ointments in use in simple surgery, would require more time than you have to give me. So I may, perhaps, be justified in stating that the most universally applicable ointment for open wounds which I know of, is one made of equal parts of carbolic acid ointment and oxide of zinc ointment. This has seemed to me to do more good than any other ointment in the case of granulating surfaces, unless they were syphilitic, and in these, I think, mercurial ointments sometimes do better. A little point in regard to the use of ointments is, that they should be confined, as nearly as possible, to the open surface. A piece of lint or muslin should be spread with the ointment, and trimmed down to the exact size of the sore. If spread on the adjacent skin, it will often, after a while, set up an artificial eczema, which is very annoying to a patient.—*Med. & Surg. Reporter.*

STANDARD DISINFECTANTS.

Disinfection of Excreta, etc.—The infectious character of the dejections of patients suffering from cholera and from typhoid fever is well established; and this is true of mild cases and of the earliest stages of these diseases as well as of severe and fatal cases. It is probable that epidemic dysentery, tuberculosis, and perhaps diphtheria, yellow fever, scarlet fever, and typhus fever may also be transmitted by means of the alvine discharges of the sick. It is therefore of the first importance that these should be disinfected. In cholera, diphtheria, yellow fever, and scarlet fever, all vomited material should also be looked upon as infectious. And in tuberculosis, diphtheria, scarlet fever, and infectious pneumonia, the sputa of the sick should be disinfected or destroyed by fire. It seems advisable also to treat the urine of patients sick with an infectious disease with one of the disinfecting solutions below recommended.

Chloride of lime, or bleaching powder, is, perhaps, entitled to the first place for disinfecting excreta, on account of the rapidity of its action. The following standard solution is recommended:

STANDARD SOLUTION No. 1.

Dissolve chloride of lime of the best quality in

soft water, in the proportion of four ounces to the gallon.

Use one pint of this solution for the disinfection of each discharge in cholera, typhoid fever, etc. Mix well, and leave in vessel for at least ten minutes before throwing into privy-vault or water-closet. The same directions apply for the disinfection of vomited matters. Infected sputum should be discharged directly into a cup half full of the solution.

STANDARD SOLUTION NO. 2.

Dissolve corrosive sublimate and permanganate of potash in soft water, in the proportion of two drachms of each salt to the gallon.

This is to be used for the same purposes and in the same way as Standard Solution No. 1. It is equally effective, but it is necessary to leave it for a longer time in contact with the material to be disinfected—at least an hour. The only advantage which this solution has over the chloride of lime solution consists in the fact that it is odorless, while the odor of chlorine in the sick-room is considered by some persons objectionable. The cost is about the same. It must be remembered that this solution is highly poisonous. It is proper, also, to call attention to the fact that *it will injure lead pipes if passed through them in considerable quantities.*

STANDARD SOLUTION NO. 3.

To one part of Labarraque's Solution (liquor sodæ chlorinatæ) add five parts of soft water.

This solution is more expensive than the solution of chloride of lime, and has no special advantages for the purposes mentioned. It may, however be used in the same manner as recommended for Standard Solution No. 1.

The following powder is also recommended for the disinfection of excreta in the sick-room and of privy-vaults, etc. :

DISINFECTING AND ANTISEPTIC POWDER.

One pound of chloride of lime ; one ounce of corrosive sublimate ; nine pounds of plaster of Paris. Pulverize the corrosive sublimate and mix thoroughly with the plaster of Paris. Then add the chloride of lime and mix well. Pack in paste-board boxes or in wooden casks. Keep dry.

As an antiseptic and deodorizer this powder is to be sprinkled upon the surface of excreta, etc.

To disinfect excreta in the sick-room, cover the entire surface with a thin layer of the powder—one-fourth inch in thickness—and if the material is not liquid pour on sufficient water to cover it.

Disinfection of the Person.—The surface of the body of a sick person, or of his attendants, when soiled with infectious discharges, should be at once cleansed with a suitable disinfecting agent. For this, Standard Solution No. 3 may be used.

In diseases like small-pox and scarlet fever, in which the infectious agent is given off from the en-

tire surface of the body, occasional ablutions with Labarraque's Solution, diluted with twenty parts of water, will be more suitable than the strong solution above recommended.

In all infectious diseases the surface of the body of the dead should be thoroughly washed with one of the standard solutions above recommended, and then enveloped in a sheet saturated with the same.

Disinfection of Clothing.—Boiling for half an hour will destroy the vitality of all known disease germs, and there is no better way of disinfecting clothing or bedding which can be washed than to put it through the ordinary operations of the laundry. No delay should occur, however, between the time of removing soiled clothing from the person or bed of the sick and its immersion in boiling water, or in one of the following solutions ; and no article should be permitted to leave the infected room until so treated.

STANDARD SOLUTION NO. 4.

Dissolve corrosive sublimate in water in the proportion of four ounces to the gallon, and add one drachm of permanganate of potash to each gallon to give color to the solution.

One fluidounce of this standard solution to the gallon of water will make a suitable solution for the disinfection of clothing. The articles to be disinfected must be thoroughly soaked with the disinfecting solution and left in it for at least two hours, after which they may be wrung out and sent to the wash.

Solutions of corrosive sublimate should not be placed in metal receptacles, for the salt is decomposed and the mercury precipitated by contact with copper, lead, or tin. A wooden tub or earthen crock is a suitable receptacle for such solutions.

Clothing may also be disinfected by immersion for two hours in a solution made by diluting Standard Solution No. 1 with nine parts of water—one gallon in ten. This solution is preferable for general use, especially during the prevalence of epidemics, on account of the possibility of accidents from the poisonous nature of Standard Solution No. 4. When diluted as directed this solution may, however, be used without danger from poisoning through the medium of clothing immersed in it, or by absorption through the hands in washing. A poisonous dose could scarcely be swallowed by mistake, owing to the metallic taste of the solution, and the considerable quantity which would be required to produce a fatal effect—at least half a pint.

Clothing and bedding which cannot be washed, may be disinfected by exposure to dry heat in a properly constructed disinfecting chamber for three or four hours. A temperature of 230° F. should be maintained during this time, and the clothing must be freely exposed—i. e., hot folded or arranged in piles or bundles, for the penetrating power of dry heat is very slight.

The limitations with reference to the use of dry heat as a disinfectant are stated in a "Preliminary Report of the Committee on Disinfectants," published in the *Medical News*, March 14, 1885.

The temperature above mentioned will not destroy the spores of bacilli—e. g., of the anthrax bacillus, but is effective for the destruction of all disease germs which do not form spores; and there is good reason to believe that this list includes small-pox, cholera, yellow fever, diphtheria, erysipelas, puerperal fever, and scarlet fever (?) Moist heat is far more effective, and it is demonstrated that ten minutes exposure to steam, at a temperature of 230 F., will destroy all known disease germs, including the most refractory spores.

In the absence of a suitable disinfecting chamber, it will be necessary to burn infected clothing and bedding, the value of which would be destroyed by immersion in boiling water, or in one of the disinfecting solutions recommended.

Disinfection of the Sick-room.—In the sick-room no disinfectant can take the place of free ventilation and cleanliness. It is an axiom in sanitary science that *it is impracticable to disinfect an occupied apartment*; for the reason that disease germs are not destroyed by the presence in the atmosphere of any known disinfectant in respirable quantity. Bad odors may be neutralized, but this does not constitute disinfection in the sense in which the term is here used. These bad odors are, for the most part, an indication of want of cleanliness, or of proper ventilation; and it is better to turn contaminated air out of the window, or up the chimney, than to attempt to purify it by the use of volatile chemical agents, such as carbolic acid, chlorine, etc., which are all more or less offensive to the sick, and are useless so far as disinfection—properly so-called—is concerned.

When an apartment which has been occupied by a person sick with an infectious disease is vacated, it should be disinfected. But it is hardly worth while to attempt to disinfect the atmosphere of such an apartment, for this will escape through an open window and be replaced by fresh air from without while preparations are being made to disinfect it. Moreover, experience shows that the infecting power of such an atmosphere is quickly lost by dilution, or by the destruction of floating disease germs through contact with oxygen, and that even small-pox and scarlet fever are not transmitted to any great distance through the atmosphere; while cholera, typhoid fever, and yellow fever are rarely, if ever, contracted by contact with the sick, or by respiring the atmosphere of the apartments occupied by them.

The object of disinfection in the sick-room is, mainly, the destruction of infectious material attached to surfaces, or deposited upon window-ledge, in crevices, etc. If the room has been properly cleansed and ventilated while still occu-

pied by the sick person, and especially if it was stripped of carpets and unnecessary furniture at the outset of his attack, the difficulties of disinfection will be greatly reduced.

All surfaces should be thoroughly washed with a solution of corrosive sublimate of the strength of one part in 1000 parts of water, which may be conveniently made by adding four ounces of Standard Solution No. 4 to the gallon, or one pint to four gallons of water. The walls and ceiling, if plastered, should be whitewashed with a lime wash containing the same proportion of corrosive sublimate, or they may be brushed over with the aqueous solution. Especial care must be taken to wash away all dust from window-ledge and other places where it may have settled, and to cleanse thoroughly crevices and out-of-the-way places. After this application of the disinfecting solution, and an interval of twenty-four hours or longer for free ventilation, the floors and wood-work should be well scrubbed with soap and hot water, and this should be followed by a second more prolonged exposure to fresh air, admitted through open doors and windows.

Many sanitary authorities consider it necessary to insist upon fumigation with sulphurous acid gas—produced by combustion of sulphur—for the disinfection of the sick-room. As an additional precaution, this is to be recommended, especially for rooms which have been occupied by patients with small-pox, scarlet fever, diphtheria, typhus fever, and yellow fever. It should precede the washing of surfaces and free ventilation above recommended. But fumigation with sulphurous acid gas alone, as commonly practised, cannot be relied upon for the disinfection of the sick-room and its contents, including bedding, furniture, infected clothing, etc., as is popularly believed. And a misplaced confidence in this mode of disinfection is likely to lead to a neglect of the more important measures which have been recommended. In the absence of moisture the disinfecting power of sulphurous acid gas is very limited, and under no circumstances can it be relied upon for the destruction of spores. But exposure to this agent in sufficient quantity, and for a considerable time, especially in the presence of moisture, is destructive of disease germs, in the absence of spores. It is essential, however, that the germs to be destroyed shall be very freely exposed to the disinfecting agent, which has but slight penetrating power.

To secure any results of value, it will be necessary to close the apartment to be disinfected as completely as possible by stopping all apertures through which the gas might escape, and to burn not less than three pounds of sulphur for each thousand cubic feet of air-space in the room. To secure complete combustion of the sulphur it should be placed, in powder or in small fragments, in a shallow iron pan, which

should be set upon a couple of bricks in a tub partly filled with water, to guard against fire. The sulphur should be thoroughly moistened with alcohol before igniting it.

Disinfection of Privy-vaults, Cesspools, etc.—When the excreta—not previously disinfected—of patients with cholera or typhoid fever, have been thrown into a privy-vault this is infected, and disinfection should be resorted to as soon as the fact is discovered, or whenever there is reasonable suspicion that such is the case. It will be advisable to take the same precautions with reference to privy-vaults into which the excreta of yellow fever patients have been thrown, although we do not definitely know that this is infectious material. Disinfection may be accomplished either with corrosive sublimate, or with chloride of lime. The amount used must be proportioned to the amount of material to be disinfected.

Use one pound of corrosive sublimate for every five hundred pounds—estimated—of fecal matter contained in the vault, or one pound of chloride of lime to every thirty pounds.

Standard Solution No. 4, diluted with three parts of water, may be used. It should be applied—the diluted solution—in the proportion of one gallon to every four gallons—estimated—of the contents of the vault.

If chloride of lime is to be used, one gallon of Standard Solution No. 1 will be required for every gallon—estimated—of the material to be disinfected.

All exposed portions of the vault, and the wood-work above it, should be thoroughly washed down with the disinfecting solution.

To keep a privy-vault disinfected during the progress of an epidemic, sprinkle chloride of lime freely over the surface of its contents daily. Or, if the odor of chlorine is objectionable, apply daily four or five gallons of Standard Solution No. 2, which should be made up by the barrel, and kept in a convenient location, for this purpose.

Disinfection of Ingesta.—It is well established that cholera and typhoid fever are very frequently, and perhaps usually, transmitted through the medium of infected water or articles of food, and especially milk. Fortunately we have a simple means at hand for disinfecting such infected fluids. This consists in the application of heat. *The boiling temperature maintained for half-an-hour kills all known disease germs.* So far as the germs of cholera, yellow fever, and diphtheria are concerned, there is good reason to believe that a temperature considerably below the boiling point of water will destroy them. But, in order to keep on the safe side, it is best not to trust anything short of the boiling point (212° F.) when the object in view is to disinfect food or drink which is open to the suspicion of containing the germs of an infectious disease.

During the prevalence of an epidemic of cholera it is well to boil all water for drinking purposes. After boiling, the water may be filtered, if necessary, to remove sediment, and then cooled with pure ice, if desired.

A sheet of filtering paper, such as druggists use, and a glass or tin funnel, furnish the best means for filtering water on a small scale for drinking purposes. A fresh sheet of paper is to be used each day.—*Med. News.*

A NEW TREATMENT OF SCIATICA.

Every physician in general practice must have at different times realized how unsatisfactory are all the modes of treating sciatica. Anodynes have failed, or are required in doses so large and frequent as to be a source of danger to the patient. All the machinery of the revulsive medication, from rubefacient terebinthine liniments to linear vesication, the actual cautery, or punctiform (Paquelin) cauterizations, have been brought to bear upon the suffering member. Electricity in all its forms has been tried and frequently proved disappointing. Local anodynes (solutions of menthol, belladonna, ether spray, chloroform) may have rendered some fleeting service. The general tone of the organism has been fortified by quinine, and the quality of the blood improved by iron and cod-liver oil, but the vitality of the *locus minoris resistentiæ* (that "greatest and worst nerve of the body," as we have heard patients say) still remains depressed. Anti-rheumatics have been tried from salicylate of sodium to colchicum and iodide of potassium, all to the point of tolerance, but all to little effect. Nerve-stretching remains, but that somewhat delicate and difficult operation has been reserved as a last resort. In view, then, of the want of success which has attended the old methods, a new method of treatment which promises comfort to physician and patient will be welcomed.

Devobe has lately proposed refrigeration by chloride of methyl in sciatica, as a medication of singular efficacy. This substance, which is obtained by distilling together methyl alcohol, sodium chloride, and sulphuric acid, is a colorless gas, slightly soluble in water, with sweetened taste and odor; when projected on a part of the body from a suitable siphon bottle, it is attended with the production of intense cold, followed by intense smarting, and if the action be sufficiently prolonged, considerable erythema and even vesication. The benefit which is claimed from this remedy would seem to be due not so much to the refrigerant as to the subsequent counter-irritant and vesicant effect. Devobe, in a late number of the *Bulletin Général de Thérapeutique*, thus explains the principle and *modus operandi* of his method:—

"When we employ revulsion under any form

whatever (vesication, punctiform cauterization, etc.) for a neuralgic affection, we act on certain of the sensory extremities of the painful nerve, but we respect a far greater number of these nerve terminations because it is not possible to multiply to any great extent our vesicatories and cautery points. A process of revulsion which may be extended to the totality of the member innervated by the affected nerve will be then of far greater efficacy. This process I have realized in employing, as a revulsive, *congelation*. To this end I have had recourse to chloride of methyl, which is readily obtainable in commerce, and with which you may produce a speedy refrigeration. I practise with this agent, using for the purpose a siphon bottle furnished with suitable stop-cock and beak, pulverizations along the diseased nerve, directing the spray especially upon the *points douloureux*. This spraying ought not to last longer than a few minutes. It is much less disagreeable than the actual cautery, and (what is more important) *it is followed by instantaneous relief of pain*. I have by this means cured patients who long had been sufferers, and who had obtained only partial relief from other revulsives. Ordinarily one séance suffices to cause the pain to completely disappear; sometimes, nevertheless, a second séance is necessary; but always after the first séance the pains are considerably lessened. When you prolong the spraying a little too long, you produce vesication. Although this is an accident of little importance, I think it better to guard against it, and as a precautionary guide, I habitually consult the feelings of the patient; when they tell me that the sensations which they experience resemble the pain which the punctiform cautery would occasion, I cease the pulverization."

This mode of treatment was lately discussed at a meeting of the Academy of Medicine. Desnos reported four cases of sciatica in which this method was tried; in three it was completely successful. The spraying from a siphon bottle was performed with great precautions, occupying only a few seconds. Rendu has found that a liability to the production of eschars follows the careless or too free use of this new medication: nevertheless, in one or two stubborn instances the most gratifying amelioration, and even cure, resulted. Bucquoi finds the methyl chloride a revulsive rather than an anodyne; in one rebellious case in his practice it was signally beneficial. Sevestre claims to have cured one inveterate case of sciatica after daily applications for two months of the methyl spray. Legroux has also found spraying with this substance useful in the intercostal neuralgias of tuberculosis. Robin, in December, obtained a striking cure by this means, in a patient forty years of age who had for six months suffered from sciatica with atrophy of the limbs; he was cured after two applications of the methyl, which were followed by vesication and intense pigmentation of

the congealed region. Letulle has treated two patients by the same process; the one was affected with sciatica from neuritis, and was completely cured; the other, who was suffering from Pott's disease, complained constantly of diffuse lumbar pains, and derived the greatest benefit from the methyl-chloride spray.

It is to be hoped that the favorable experiences of these French practitioners with this new remedy may be followed by equally good results in this country, and that this painful, inveterate malady may become less of an opprobrium to medicine and surgery.—*Boston Med. Journal*.

HEAT AS A DISINFECTANT.

Dr. George H. Rohe gives the following in the *Medical News* regarding dry heat as a disinfectant: The first accurate observations on the disinfecting power of dry heat were made by Henry, of Manchester, in 1831. (Quoted in E. Vallin: *Traite des désinfectants*, Paris, 1882, p. 226). Henry exposed (fresh?) vaccine virus to temperatures varying from 50° to 82° Cent. (122°–180° Fahr.) for two, three, and four hours, and secured complete disinfection, none of the specimens of vaccine thus exposed producing vaccinia when subsequently inoculated. Exposure for three hours to a temperature of 49° C. (120 F.) failed to disinfect. No contra experiments with non-disinfected virus was made by this observer.

E. B. Baxter *Report Medical Officer of Privy Council*, etc., N. S., No. vi, p. 216) exposed dry vaccine to a temperature of from 90°–95° C. (194°–203° F.) for thirty minutes. Disinfection was complete. Vaccination with disinfected virus was unsuccessful. Contra inoculations with non-disinfected virus were successful.

Koch and Wolfhügel (*Mitt. a. d. Kais. Gesundheitsamte*, Bd. I.) experimented with a large number of pathogenic and non-pathogenic organisms. A temperature varying from 78°–123° C. (172°–253° F.) maintained for one hour and a-half (over 212° F. for an hour) sufficed to kill micrococcus prodigiosus and the bacilli of septicæmia of mice and rabbits, but failed to destroy the spores of bacillus anthracis and of various non-pathogenic bacteria and fungi. Micrococci and bacilli containing no spores, and spores of mould fungi, were completely killed by one and a-half hour's exposure to a temperature of from 120°–128° C. (248°–262° F.); but spores of *B. subtilis*, *B. anthracis*, and of a bacillus growing upon potato, resisted a second heating to the same temperature for a similar length of time.

These authors further experimented upon a number of organisms disposed in various ways in the disinfecting chamber, so as to approach in a measure the conditions of practical disinfection. Some of the articles were placed in coat pockets,

others rolled up in balls of cotton, oakum, blankets, or soiled clothing, making packages of different thickness and density. The organisms consisted of micrococcus prodigiosus, micrococcus of blue pus, bacillus anthracis, and bacilli found in garden soil. With each package was placed a registering thermometer to indicate the highest temperature reached during the experiment. The temperature in the chamber varied from 133° to 156° C. (271 – 313° F.), and the exposure was continued for three hours and ten minutes. The temperatures in the different packages varied from 74.5° C. (167° F.) to 121.5° C. (251° F.). In none of the packages were the spore-bearing organisms destroyed. In a small iron vessel hanging free in the chamber and containing specimens of the same organisms, a temperature of 139.5° C. (283° F.) was indicated by the thermometer. Here complete disinfection had taken place.

Another series of observations with the temperature in the chamber varying from 131° – 140° C. (267 – 284° F.), and exposure continuing for three hours, resulted as follows: The organisms (micrococcus prodigiosus, spores of bacillus anthracis, and of bacilli of garden soil) and registering thermometers were enclosed in packages of clothing, bedding, and rolls of blankets. Complete destruction of the spore-bearing organisms did not follow unless the temperature of 139° C. (282° F.) had been reached. In one large package consisting of nineteen blankets, thoroughly dried and rolled up, the heat did not penetrate to the interior in a sufficiently high degree to destroy the vitality of micrococcus prodigiosus even.

He submits the following conclusions:

1. A temperature of 100° C. (212° F., dry heat), maintained for one hour and a-half, will destroy bacteria which do not contain spores.

2. Spores of mould-fungi require for their destruction in hot air, a temperature of from 110° – 115° C. (230° – 230° F.) maintained for one hour and a-half.

3. Bacillus spores require for their destruction in hot air a temperature of 140° C. (284° F.), maintained for three hours.

4. In dry air the heat penetrates objects so slowly that small packages, such as a pillow or small bundle of clothing, are not disinfected after an exposure of from three to four hours, to a temperature of 140° C. (284° F.).

5. Exposure to a temperature of 140° C. (284° F.) in dry air for a period of three hours injures most objects requiring disinfection (clothing, bedding, etc.) to a greater or less degree.

form and degree of severity, in every variety of diathesis and complication, however chronic or acute, have been treated by the use of the pure rubber or "Martin" bandage—applied to the limb from the foot to above the knee. The joint is previously strapped from three inches above to a corresponding point below the patella, with non-irritating rubber plaster. This strapping is not applied for the ordinary reasons, but to obviate, or at least mitigate, a troublesome chafing of the skin in the popliteal space, from walking exercise while the bandage is on the limb. One such strapping will remain *in situ* for four or five weeks, and in a very large proportion of cases has not to be repeated. The plaster, however, must be perfectly non-irritating. The bandage should be applied as tightly as the patient can wear it with comfort. There is no danger of the circulation by following this rule, as no dangerous constriction of the limb could be endured without pain and discomfort. The bandage thus applied should be worn in general for from four to six weeks, according to the severity of the case, day and night; and, after that, during the day only, or while in the upright position, for from four to eight weeks longer. Many patients prefer to wear them a good deal longer, to prevent any possible return of trouble, but this is in general not at all necessary.

When the bandages are thus applied, great comfort and support are at once experienced, and with these much increased capacity to use the joint. Very soon it becomes evident that absorption of effused fluid, and of the interstitial deposits in the tissues of the synovial sac, and of the other tissues about the joint, is going on; and, in a space of time too short to be credible to those who have not accurately pursued the practice, and carefully and repeatedly observed the fact, the enlarged and weakened articulation is restored to the normal size, and if not immediately to its original strength, to a far greater capacity for use, and eventually to a perfect restoration in all respects.

In cases where the amount of fluid effusion within the sac is small, or where the thickening of the sac is the principal element of the case, these results may be always looked for with certainty and rapidity. Sometimes, however, when the amount of fluid effusion is very large, the use of the bandage *alone* (although of the greatest value as a palliative, by strengthening the joint, and permitting painless use of the limb) will produce *complete* absorption of the fluid very slowly, if at all. The existence of these exceptional obstinate cases induced my father, some twelve years ago, to add to the use of the bandage a preceding thorough aspiration of the sac, all the other points of treatment being exactly as before described. This was done at first only in exceptionally obstinate cases, in which the effusion within the synovial sac was large, but the operation was gradually found to be

MARTIN'S METHOD OF TREATMENT OF SYNOVITIS, ESPECIALLY OF THE KNEE-JOINT.—During the past thirty-one years over four hundred cases of synovitis of the knee and its sequelæ, of every

entirely free from danger, and latterly aspiration has been practiced in all cases in which, being chronic, the synovial effusion is of any considerable amount, and even in the most acute cases in which rapid effusion produces great distention and consequent pain.

The results of my father's experience are summed up in the following statements :

1. In the last twelve years over two hundred cases of synovitis of the knee, and its sequelæ, have been treated by aspiration with a single strapping of the joint, and subsequent use of the bandage.

2. In these cases the knee-joint has been punctured over four hundred times.

3. In all these cases, with the exception of a very few, and these only in the early stages of treatment, the patient was not only permitted, but obliged to take a daily and considerable amount of walking exercise.

4. In not a single instance has there been failure of absolute and entire cure, requiring, in one case, seventeen weeks, but in no other more than eleven weeks.

5. Although no antiseptic measure, beyond perfect cleanliness of the aspirating needle, was employed, in not one instance has any ill symptom followed the operation. When the needle is withdrawn, the puncture is at once covered securely with adhesive plaster.

Sir Benjamin Brodie long ago declared most emphatically, that when the synovial sac is distended with fluid, it can be punctured, and the effusion drawn off with perfect safety. He does not by any means regard this as a help in treatment, however, as he says the fluid will accumulate again, and in a few hours the joint will be as much distended as before. The originality and value of my father's method of treatment lies in successfully demonstrating the fact that thorough aspiration of the knee-joint, followed by proper use of the rubber bandage, gives us a complete and satisfactory method of cure even in the worst cases of synovitis. By the firm and equable pressure of the rubber bandage, the re-accumulation of fluid is checked. If there is any return of the fluid at all, it is in very much diminished quantity, and a second, or perhaps in severe cases a third, aspiration of the joint is all that is ever required. One great advantage of it is to explode the idea that perfect rest of the joint is the only way to hope for a cure. The patient is emphatically *not* to be confined to bed, or, worse still, to a fixed splint. When the joint is strengthened by a properly applied rubber bandage, exercise is a very great and important adjunct in the treatment. This very day I have visited a lady who passed last summer in Switzerland. While there she was attacked with synovitis of the left knee, with a large amount of effusion into the sac. She was kept in bed,

with the limb placed on a fixed splint and continually poulticed. After sweltering through the hot weather with the limb swathed in many thicknesses of cotton wadding, at the expiration of two months the splint was removed, and—she has come home with a joint almost immovable! I am sure that had this case been treated by prompt aspiration of the sac, and the proper use of the rubber bandage, a perfect and rapid cure would have resulted without a week's confinement of the patient to her bed.—*Medical Record*.

AMPUTATIONS AND EXCISIONS.—Speaking of amputations, Mr. Banks, of Liverpool, *Med. Record* (N.Y.) naively remarks that for his part he only knows and only teaches two things about them, viz., to make one flap longer than the other and to saw the bone as low down as possible. I may remark that the size of the flaps is a question on which surgeons differ greatly. Many British surgeons are now in favor of having two flaps of nearly equal size. The "circular" method has also many advocates.

In amputating through the femur for disease of the knee-joint it is difficult, says Mr. Banks, to see any use in keeping the patella. Sawing off its cartilaginous surface and then trying to make it stick on to the cut end of the femur may afford an operator of a mechanical turn of mind some amusement, but nothing more. It is not the patella we want, but the hard skin over it.

In describing a case of double amputation for railway injuries, Mr. Banks alludes to rapidity of operating as an element in prognosis. In this case the patient, a boy of ten years of age, had fallen from a train and lay in a tunnel all night in severe wintry weather. He was apparently dead when brought to the hospital, but some signs of life appeared after a time. Subcutaneous injections of ether were given him (two of thirty minims each) and "he was placed on a mattress opposite a large fire and literally cooked into life again." Reaction had fairly set in by the evening. He was then taken into the theatre, "the smallest whiff of ether" was given him, while the two injured limbs were removed "with all the rapidity possible." Rough dressings of lint soaked in carbolized oil were applied, and the patient "was again in the ward on the mattress before the fire in less than fifteen minutes from the time of his removal." Space fails me to give the full history of this most interesting case, but I may say that the patient was attacked with "surgical scarlet fever," the urine became albuminous, the flaps opened up and refused to heal, and the bones protruded. The patient eventually recovered, a result largely due, Mr. Banks believes, to the speed with which the operations on him were performed. He remarks that in these days of anæsthetics the surgeon is apt to proceed too deliberately, forgetting that the patient, though not suffer-

ing pain is suffering shock—that “every minute of anæsthesia, every fresh incision, every lost teaspoonful of blood,” lessens his chance of recovery. Mr. Banks goes so far as to say that in a thigh amputation for smash, the fact of the patient being on the table twenty minutes in one case, or forty-five in another, makes all the difference “between his crossing the bar and sticking on it.” In the case just alluded to, the warm fire, subcutaneous injections of ether, the selection of ether as an anæsthetic, and the careful use of antiseptics, all no doubt aided in procuring the favorable result.

Mr. Banks is a warm advocate of ether as an anæsthetic, and even goes so far as to say, “To-day it has elbowed chloroform out of the field.” This may be so in Liverpool; it certainly is not so in London. Chloroform is still largely used both in hospital and private practice. The A.C.E. mixture is becoming more generally used also. Local anæsthesia is becoming more largely employed. Ether-spray, or ice and salt, is much more often made use of for minor operations than formerly. The introduction of cocaine has stimulated investigators to try and discover some other local anæsthetizing agent. Mr. Banks recognizes two objections to ether. One, the danger of excessive secretion of mucus in bronchitic patients; the other, its failure to thoroughly control muscular action even after feeling is abolished.

Mr. Banks has some very thoughtful remarks to make on the subject of excisions. At the International Medical Congress in London (1881) Mr. Howard Marsh ignored statistics and pointed out that excision belongs to the same class of treatment as amputation. It is giving up the attempt to cure the disease. To this view Mr. Banks cordially assents. Far better than advocating early excision is it, he says, to devote ourselves to teaching the early recognition of hip and joint disease. “The children of rich people,” he says, “don’t have their hips and knees excised. Why not? Because the articular mischief is promptly found out, and skillfully and patiently treated.” Joint diseases are so prevalent in the cold and damp climate of Liverpool, that Mr. Banks’ opinion is worth hearing at any rate. I may remark that the Clinical Society’s report (1881) on excision of the hip-joint, showed a mortality of thirty-five per cent. in cases of excision as against thirty in cases of supuration treated by rest and extension.

Mr. Banks says the following is his teaching to students: “In children up to fifteen years of age, if you get a case of knee or hip disease from its commencement, make up your mind to save the limb. You ought to save it. Between fifteen and twenty-five, failure is to be looked for very often, and then you may excise. Don’t operate until your art is exhausted—only don’t wait until your patient is exhausted. Fortunately after twenty-five or thirty, joint mischief is not common; but

at that age whatever you may do with the hip, do not excise the knee, if your patient will let you amputate.”

Mr. Banks says that his impression of excision of the knee-joint after thirty years of age is that it is, as a rule, disastrous, and that many a life has been lost to save a leg. On this question many surgeons will be disposed to join issue with Mr. Banks, but one remark that he makes is certainly worth remembering. It is that a workingman does not usually do a stroke of work on an excised knee-joint under eighteen months or two years; after amputation he is at work in from four to six months on a sound stump.

CASE OF CÆSAREAN SECTION PERFORMED BY THE PATIENT HERSELF.—The following remarkable case was related by Dr. von Guggenberg, and the patient exhibited, at the last annual meeting of Bohemian physicians at Tetschen. On September 28, 1876, he was summoned at two in the morning to see a woman, who was said to have cut open her abdomen. He found the patient lying in a miserable house, on a wretched and dirty bed, exhausted and bloodless, and only capable of making affirmative and negative signs. On removing a dirty petticoat which covered her, an incised wound was seen on the right side of the abdomen, passing downward and inward, from which a somewhat large coil of intestine protruded, the greater part of which, covered with dried blood, rested upon a dirty blood-soaked straw sack. Hæmorrhage seemed to have ceased from every part of the wound, and the uterus was contracted to the size of a child’s head. A fully developed, but dead, male child lay between the patient’s knees. Clean linen was procured from a neighboring house, and, with a piece soaked in oil, the protruded intestines were carefully wiped and returned, and the wound sewed up, the peritoneum being included with the skin. The incision was about three and a half inches long, and slightly S-shaped. It was dressed with a five-per-cent carbolic solution, fixed with strapping, and the abdomen was carefully bandaged. By the afternoon, the patient was able to speak, and next day the history was taken. She had had seven children previously, four of whom had been born without medical assistance, two with forceps, and one after craniotomy. The pains began between September 24th and 25th, ceased in the afternoon, and came on again on September 26th, when the midwife stated that she felt the presenting head on vaginal examination. On September 27th, convulsions came on, according to the patient’s account, accompanied by agonizing pain and great distension of the abdomen, the movements of the child ceasing. The pain and distension became so severe that the patient determined to perform Cæsaean section, of which she had heard. She therefore took a razor and divid-

ed the skin slowly; she then made a second and a third incision; and finding the child not yet appearing, made another cut, which caused a large jet of blood to escape, and exposed the placenta; this she removed. One foot of the child came into view, which she seized and pulled upon until the whole of the body came through the wound, the head requiring the exertion of all her force. She divided the umbilical cord, laid the child (which she believed to be dead) beside her on the bed, and threw the placenta on the floor. She had passed neither urine nor feces since September 24th. The progress of the case was very good; urine was passed on the afternoon of September 28th, but the first stool not till October 2d. The pulse reached one hundred and twenty on the day after the operation, but was never again so frequent; the temperature is stated to have been not very high; and, although there was a considerable amount of exudation from the wound, it had united by October 3d. The patient soon returned to work, and has been ever since in perfect health.—*British Medical Journal*.

TREATMENT OF GONORRHOEA—In the early treatment of gonorrhœa, Prof. Gross condemns the use of injections. His plan is as follows: If possible, put the patient to bed; give him at the outset a purge, by administering Epsom and Rochelle salts, each \mathfrak{z} ij, in lemon syrup. Allow no meat or any stimulating articles of diet, etc. Malt liquors do more harm than alcoholic, so interdict both. No tea or coffee, but give him milk, eggs and some oysters, etc. Three times daily he is to hold the penis in a cup of hot water—quite hot. Keep the organ there for five minutes at a time, then wipe it gently each time.

The internal treatment will be by the "antimonial and saline mixture":—

R. Antimonii et potassii tartrat., gr. $\frac{1}{16}$
 Magnesii sulphatis, \mathfrak{D} ij
 Morphinæ sulphatis, gr. $\frac{1}{16}$
 Tinct. aconiti radicis, gtt. j
 Liquor. potassii citrat., f \mathfrak{z} ss
 Olei limonis, gtt. ss
 Elixir. simplicis, f \mathfrak{z} ss. M.

SIG.—Ter die.

By this treatment the urine will be rendered bland and unirritating. Should the urine persist in "scalding," then add to the above prescription gtt. x tinct. cannabis indicæ. To prevent or cure chordee, order at night a suppository of—

R. Extract. opii,
 Camphoræ, aa gr. iij.

In the course of four or five days the discharge from the urethra will look more like laudable pus; then order an injection:—

R. Hydrargyri chloridi corrosivi, gr. ij
 Aquæ destillat., O j.

SIG.—With syringe that holds an ounce, inject into the urethra—having first "flushed" the canal several times by voiding urine—and retain the fluid for five minutes.

Internally, a useful combination is that used at the out-door department at the hospital, and consisting of—

R. Cubebæ, \mathfrak{z} ij
 Alum. pulv., \mathfrak{z} j. M.

SIG.—Of this take a heaping teaspoonful in a tumbler of water ter die; the dose to be increased.

Should the discharge per urethram still persist, use an injection of—

R. Liquor. plumbi subacetatis, f \mathfrak{z} j
 Aquæ, f \mathfrak{z} x. M.

Or—

R. Plumbi acetatis, gr. ij
 Zinci sulphat., gr. iij
 Aquæ, f \mathfrak{z} j. M.

Or—

R. Acidi tannici, gr. ij
 Aquæ, f \mathfrak{z} j. M.

—*Coll. and Clin. Record*.

MONSEL'S IRON IN DIARRHOEA.—Dr. E. T. Williams (*Boston Med. and Surg. Journal*), says: "Ever since I began practice in 1868 I have been looking for a really satisfactory astringent in chronic catarrh of the bowels. There is, as everyone knows, a class of cases where the ordinary vegetable astringents fail to act, or at least act too feebly to do real good. The intestinal lining is in an ulcerous, or quasi-ulcerous, condition, and requires the potent action of a mineral astringent to treat it, as in cases of external ulcer. The acetate of lead is one of the best remedies in these cases, but cannot be safely given for any great length of time. Oxide of zinc in pill form is safe and efficient, but with children, who must take it in powder, often vomits and gripes. Sulphate of copper and nitrate of silver are still harsher, and for children quite out of the question. Subnitrate of bismuth is worse.

"I began trying, in 1876, at the Seashore Home, iron alum (the officinal sulphate of iron and ammonia). I found it better than anything I had previously tried, and have used it freely ever since. It is not quite so well borne by the stomach as lead and bismuth, but far better than zinc or copper. The dose for a child is from one to three grains; for adults, from three to ten. At the Seashore Home we make powders containing one grain of the salt to a twelfth of a grain of opium, giving one or more for a dose according to the age of the child. For adults the pill form is of course preferable. I have had the best results from its use.

"Last summer I began using Monsel's salt in

its place, both in public and private practice. This I did from my experience of its great efficiency as a styptic, and a presumption that it might do equally well in diarrhoea, and have found it even better than iron alum. I have tried it only in the dry form, manufactured by Squibb under the name of pulvis ferri subsulphatis. In this State it is not officinal, though it is precisely the same as the officinal liquid ferri subsulphatis evaporated to dryness. It may be given in the same doses and in the same way as iron alum."

POPLITEAL ANEURISM SIMULATING SARCOMA.—The diagnosis of popliteal aneurism is not generally a matter of great difficulty, still some of the cases of aneurism simulate other diseases so closely that mistakes are occasionally made. Many able surgeons have opened aneurisms, supposing them to be abscesses, and others again have tied the femoral artery for malignant growths, mistaking them for aneurisms. There are not a few cases recorded where an old consolidated aneurism has been mistaken for a sarcomatous tumor. In the January issue of the American Journal of the Medical Sciences Dr. Francis J. Shepherd, of Montreal, reports an obscure and instructive case of popliteal aneurism, which was under observation for several weeks, and in which there was a total absence of aneurismal symptoms, and the rational symptoms pointed to sarcoma, either of the periosteum or the parts about an old popliteal aneurism, for which the patient had been successfully treated some years before. Amputation was performed, and an examination of the tumor showed it to be solid throughout and composed of fibrin, solidified *en masse*. The orifice of the aneurism was at the distal end of the tumor, and the blood therefore flowed from below up, with, of course, a lessened stream; the circulation, owing to the obliteration of the femoral above the tumor, being carried on by collateral branches. As there was no cavity in the tumor the absence of pulsation and bruit is explained. As there was not a single symptom which pointed to aneurism an accurate diagnosis seems to have been impossible.—*Louisville Med. News*.

THE THERAPEUTIC VALUE OF MILK.—In *L'Union Medicale du Canada*, Dr. H. E. Desrosiers has a very interesting lecture on the above subject. Milk may be used constitutionally and locally. Internally, it is, first of all, a very valuable restorative. It is an article of diet that can be borne when everything else is rejected; and in general the patients like it. It may be used in all diseases characterised by anæmia, debility and asthenia. Among the diseases in which it is most commonly used may be mentioned, idiopathic anæmia, chlorosis, convalescence from debilitating diseases, inflammatory and febrile affections, in cachexias,

etc. M. Dujardin-Beaumetz insists upon a milk diet in tuberculosis.

In the above diseases, a milk diet need not always be prescribed to the exclusion of other food. Milk is expressly indicated in the treatment of certain special diseases, such as irritative dyspepsia, gastric catarrh, gastric ulcer, cancer of the stomach, chronic intestinal indigestion, chronic diarrhoea, especially in children; in acute and chronic nephritis, diabetes mellitus, cystitis (especially chronic), gout, aneurism, and organic disease of the heart. In regard to the last, milk is used with most benefit in the period of non-compensation (the *adynamic* period of Peter). Milk has no appreciable effect in affections with compensatory hypertrophy. The intravenous injection of milk has been proposed in profound anæmia, following hemorrhage, etc.; this treatment has met with a certain degree of success in the hands of most observers.

Locally warm milk is a good gargle in acute pharyngitis and tonsillitis. It has also been recommended in diphtheria.

Sometimes skim-milk is preferred by the patients; and it even seems to be better than pure milk in interstitial nephritis. Skim-milk seems easier to digest in gastro-intestinal disorders. It has been employed with success to reduce obesity. Tyson says that it is better than any other article of diet in glycosuria.

Buttermilk, too, has its adherents; and it seems preferable to pure milk in the treatment of the gastro-intestinal disturbances above mentioned.—*N. O. Med. and Surg. Four.*

NEW OPERATION FOR RUPTURED PERINEUM.—Dr. A. C. Post read a brief paper on this subject before the N. Y. Academy of Medicine. He said that the operation had not been performed a sufficient number of times to entitle it to be regarded as established, but in the three cases in which he had performed it the result had been so satisfactory as to lead him to recommend it to the profession as worthy of trial. The operation was simpler in execution than the one ordinarily performed, and he thought it secured a more solid perineal body, and it also had the advantage that there was no loss of substance in its performance, and consequently it might be easily repeated if for any reason the first operation should fail.

An incision was made each side of the vagina to the depth of fifteen or twenty millimetres. The incisions met in front in a manner to divide the parts into an upper and lower segment. The upper segments were turned up and formed the floor of the vagina, and were secured in position by a row of catgut sutures passed, not through the skin, but through the subcutaneous cellular tissue so as to turn the edges of the skin upward to form a ridge on the floor of the vagina. A second row of sutures, of silver wire, were passed from either side

through the deepest part of the incisions, where the upper and lower segments met. The ends of these sutures were passed through glass beads and perforated shot, and after the flaps were brought into close contact the shot were compressed. The inferior edges were united by fine sutures, and an iodoform dressing was then applied. The integument on the inner side of the thighs should be protected from pressure by the shot and beads. The patient should be allowed to urinate without the use of the catheter, and the parts be washed afterwards with a solution of mercuric bichloride. The sutures might be removed at the end of ten days or a fortnight.—*Med. Times.*

A NEW ABDOMINAL DRAINAGE TUBE.—Dr. H. Marion Sims describes the following new abdominal drainage tube in the *N. Y. Medical Journal*: "It acted so nicely and drained the pelvis so well that he wished to call the attention of the medical profession to it. It consists of a large and a small tube made of hard rubber. The smaller tube is inside of the larger one, running along the posterior wall, and terminating about an eighth of an inch from the bottom. The large



tube is perforated on the sides and curved on the top, so that, when in the abdominal wound, the top of the tube projects nearly over the symphysis pubis. The smaller tube is for the purpose of washing out the peritoneal cavity, the water being thrown in at the bottom of the cavity instead of at the top, as in most draining-tubes. He attaches a

small rubber tube at B, and forces the water to the bottom of the tube C with a Davidson's syringe. At the mouth of the tube A he attaches a large rubber tube, and, while washing out, the water runs into a bed-pan or any convenient vessel placed in the bed. Where drainage is constant and very profuse, the rubber tube can be long enough to hang over the side of the bed into some vessel placed there. By having the smaller, or washing-tube project through the dressing on the wound, the pelvic cavity can be washed out without removing the dressing, which will remain dry and clean.

CHLORAL HYDRATE AS AN ANTISEPTIC.—Dr. Warner of Worcester, in a communication to the *Boston Medical and Surgical Journal*, states, that, during the last ten years, he has used a solution of chloral (three to five grains to the ounce) as almost his only dressing, and has found it acts admirably; as, while it is inodorous itself, it removes the foetor of purulent discharges effectually. It is cheap, and simple in its application, and, causing no stain, can be sprinkled freely about. It seems also to act as a local sedative, often so relieving pain of a recent injury or operation as to render resort to an opiate unnecessary. During the treatment of large suppurating wounds, it keeps the air of a ward or room pure; while there is no danger from its absorption, and the comfort from a light compress moistened in the solution is very great. Somewhat frequent changes are required to prevent the compress from becoming dry and sticky, and secure perfect cleanliness. It acts as a perfect germicide, rendering spraying quite unnecessary. In a solution in warm water, the hands of the operator, instruments, sponges, etc., are cleansed. Dr. Warner speaks of his experience of its employment in various operations producing large surfaces, and greatly prefers it to carbolic acid and other antiseptics. Chloral may also be used with cosmoline or glycerine in the same proportions, if there is any reason to prefer this form of preparation.—*Pop. Science News.*

HOW TO TREAT THE ATTACHMENTS OF UTERINE TUMORS.—Dr. Thomas Keith, (*Brit. Med. Journal*) says: I have no one way in dealing with the attachments of uterine tumors. At present each case must be a law unto itself, and of this part of the operation there is much to be learned. A few of the simpler cases may be treated extra-peritoneally. Generally the broad ligament must be left inside, and sometimes the whole attachment, when there is much enucleation, must be so treated. Sometimes the treatment may be entirely intra-peritoneal by means of Kœberlé's *serre-neud*, or it may be half intra- and half extra-peritoneal. These cases require much care in the after dressing, though the convalescence is much shorter than

when the whole is left outside. I am hopeful that the cautery will yet be the safest and best of all the methods of dealing with some of these tumors. The more I use it in ovariectomy the more I like it. It is simply perfect, and its employment seems to me "a higher exercise of our art" than the ligature, which, apart from the chances of hemorrhage, embraces ten times the amount of tissue that is really necessary. That a more perfect way will soon be found I have little doubt. This will do as much for uterine tumors as Baker Brown's intraperitoneal method has done for ovariectomy ever since 1864.

EXTIRPATION, BY LAPAROTOMY, OF A HYDATID CYST OF THE LIVER.—Dr. Guttierrez reports this curious case in *El Dictamen (Le Progrès Medical)*. A boy, 8 years of age, suffered from a tumor situated in the right iliac fossa and as large as a foetal head. Capillary puncture gave a clear fluid containing numerous hooklets, which were insignificant. It having been decided to extirpate the tumor, the right side of the abdomen was opened by an oblique incision, and the tumor dissected from its adhesions to the epiploon, of which a portion was also removed to avoid its mortification. After opening the cysts, which had increased rapidly in size after the exploratory puncture, there was discharged with the fluid the great pouch or hydatid, which had as its external envelope the thickened capsule of Glisson, which the hydatid had by degrees disengaged from the external surface of the liver until it had lodged in the iliac fossa; the operator extirpated the fibrous envelope from its hepatic attachment to prevent any suppuration that might compromise the result of such a brilliant operation. He then applied three sets of sutures, very fine catgut, including first the peritoneum, then the divided muscles, and, finally, the skin, using Lister's dressings. There was not the slightest trace of peritonitis, but reaction from the effects of the operation was slow; the wound healed perfectly, however, and digestion was normal.—*Fourn. Am. Med. Association*.

CORROSIVE SUBLIMATE AND GLYCERINE IN EPITHELIOMA OF THE CERVIX UTERI.—D. Biddle in the *Brit. Med. Journal* says: There are few things in the way of palliative treatment that have given me greater satisfaction than the use, in a case of epithelioma of the cervix uteri, of a lotion, or injection, containing one-fourth of a grain of corrosive sublimate, and half an ounce of glycerine, to a pint of water. Before using it, a patient of mine had, for seven or eight months, been subject to paroxysms of agonising pain, and to frequent hæmorrhages, which were occasionally profuse. Immediately upon its employment, and for the last three months of her life, hæmorrhage became merely nominal; and, instead of agonising pain,

there was simply the distress consequent upon irritation (by the tumor) of the bowel and bladder, the latter of which became perforated a week before death. I attribute the beneficial change to the very marked reduction in the amount of infiltration. The lotion was used continuously, with very few exceptions, twice a day during the three months, and I shall certainly adopt the same treatment in the next case I have, even before recovery is despaired of. In the case referred to, it was not tried until the curative effects of chromic acid had been tried in vain.

CARBONATE OF AMMONIA IN SCARLET FEVER.—Dr. A. W. Jackson, of Brooklyn, writes calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.—*The Medical Record*.

TREATMENT OF ZONA.—Dr. Fabre recommends the following treatment of zona: In the beginning of the disease, mild purgatives may be necessary. These should be followed by general sedatives, such as opium, belladonna, and ether, to diminish the pain. Locally, anodyne liniments may be applied and the diseased parts dusted with subnitrate of bismuth or oxide of zinc. If the vesicles are fresh and transparent, they may be aborted by covering them with collodion; but if they have been present four or five days, application of collodion will have no good effect; but, on the contrary, they will suppurate beneath it. The neuralgia which persists after the cure of the eruption should be treated by hypodermic injection of morphine or atropine, and arsenious acid in doses of from $\frac{1}{30}$ th to $\frac{1}{8}$ th of a grain be administered internally.—*L'Union Médicale*, Feb. 26, 1885.—*Med. News*.

ANTISEPTIC SILK.—Freeman uses Chinese twist which has rendered aseptic by boiling for ten minutes in a two-per-cent. solution of chromic acid, and then soaking for twelve hours in a one-per-cent. solution of the same. He states that the sutures may be left *in situ* for three weeks without the occurrence of either suppuration or softening of the silk. Silk thus prepared is especially useful in operations about the genital organs in women as well as in laparotomy.—*N. Y. Med. Journal*.

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TORONTO, MAY, 1885.

The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

THE USES OF IODOFORM.

Among German surgeons iodoform is more extensively used than any other antiseptic in the treatment of wounds. This substance, while less likely to be followed by toxic effects than carbolic acid, is not entirely free from danger. But whilst its careless use may occasion unpleasant symptoms, one very excellent feature in its favor is its freedom from irritating qualities. It may be applied directly to extensive raw surfaces, or dusted into large abscess cavities, without any fear of provoking irritation, and it is only when used in excessive quantities that danger from poisoning may be apprehended. Unlike carbolic acid, it does not increase the amount of serum from a wound.

The utility and general applicability of iodoform is much impaired by the fact that it is insoluble in water. It cannot therefore be used for irrigation, washing, cleansing, disinfecting instruments and the like. It is soluble in ether, collodion and glycerine in the proportion of about one part to ten of either menstruum, and these solutions may be used for dressing wounds. In the treatment of wounds it is generally used, however, in the form of powder, or gauze in which the meshes are thoroughly impregnated with iodoform by dusting and rubbing with the hands. An ointment of varying strength is also frequently used in the treatment of ulcers. Iodoform has been in use for several years past in the Toronto General Hospital in the treatment of chancroid and syphilitic ulcers, chronic

ulcers, compound fractures and all unhealthy wounds, and the results have been most satisfactory.

Iodoform is used largely by Billroth and others in the Vienna clinics. Iodoform gauze is the favorite application after operations, especially about the face and throat, in compound fractures and resection of joints. Billroth claims that iodoform possesses anti-tuberculous properties in addition to its antiseptic qualities, and consequently employs it freely in all joint diseases of a scrofulous character. After resecting and removing all diseased bone, the cavity is packed with iodoform gauze. The gauze is used in the same way in the treatment of compound fractures and abscess cavities. Strips of the gauze are packed in alongside the fragments of bone, and in abscess cavities, until the space is completely filled, and over this is placed layers of iodoform gauze and this dressing allowed to remain for several days.

One very effectual method of applying iodoform to an ulcer or wound is by atomization, by means of a spray producer, of an ethereal solution made by dissolving one part of iodoform in from seven to ten parts of ether. Evaporation of the ether takes place in a few minutes, leaving a thin film of iodoform evenly distributed on the surface of the wound. Another very convenient method, when it is desirable to introduce it into a sinus, or abscess cavity, is to inject a solution of one part of iodoform to ten of glycerine, after the cavity has been well washed out. Gynæcologists have for some years past been in the habit of using iodoform as an antiseptic coating for uterine tents, also in cases of endometritis, puerperal septicæmia, and as a palliative and to correct the fœtor of the discharges in cancer of the uterus and rectum. It is not only valuable in removing the fœtor, but also in alleviating the pain and suffering in these distressing affections.

The internal use of iodoform is somewhat limited. Within the past year or two it has been used in the treatment of secondary and tertiary syphilis, when iodide of potassium could not well be borne. We have in our own experience seen some benefit derived from its internal administration in chronic ulcer of the stomach. It has also been used with indifferent success in chronic diseases of the lungs. The dose is from one-half to three grains in the form of a pill.

RESORCINE IN WHOOPING-COUGH.

This remedy has been extensively employed during the last year in the treatment of whooping-cough, with more or less success. Dr. Moncorvo, of Rio de Janeiro, was among the first to bring the treatment into general notice. He strongly advocates the topical employment of resorcine in the strength of one per cent, applied by a fine pencil-brush to the larynx. He gives fourteen instructive cases, of various degrees of severity and duration, in which this remedy was found by him highly serviceable. He gives the following conclusions :

1. That whooping-cough—whose nature, up to a very recent period, has been subjected to the most diverse interpretations, in relation to its genesis—may, to-day, according to the latest microscopic researches, be included in the class of parasitic diseases.

2. That the disease appears attributable to the presence of micrococci which multiply prodigiously in the hyperglottic vicinity of the larynx, infiltrating its epithelial cells, which appear to be the predilective seat of their development.

3. That resorcine, applied to the laryngeal mucous membrane, caused, in all the cases in which it was employed, rapid decrease of the number of paroxysms, moderation of their intensity, and finally recovery in a short period of time, without the aid of any other medication.

Dr. Moncorvo says that resorcine, owing to its less caustic action, and the absence of disagreeable taste and odor, is far preferable to carbolic acid. He has administered it internally to children, even the newly born, suffering under diarrhoea and dysentery. He advises that strict attention be given to the quality, so as to secure the article in purity ; and he recommends that prepared by Monnet, of Geneva, which is of notable whiteness, and in the form of silvery bright crystalline needles. It is extremely soluble in water. Dr. M. recommends the topical application with the fine pencil-brush, to be repeated every two hours. The first applications, he says, sometimes exacerbate the coughing fits, but this irritation ceases in two or three days. In twenty cases treated by him, he was not disappointed in his expectation in a single instance ; and some of them had been very obstinate, or even dangerously complicated, as with hereditary

syphilis, threatened hydrocephalus, pulmonary tuberculosis, intermittent fever, etc.

Resorcine, in its source, being a congener of carbolic acid, no doubt acts in a similar manner as a parasiticide. Dr. Moncorvo states that he has, by numerous microscopic examinations of sputa expectorated by his patients laboring under whooping-cough, verified the statements made by Letzerich, Henke, Steiner, Hagenbush, and other writers, as to the parasitic character or complications of the disease. The treatment advocated by him is, therefore, free from all insinuation of empiricism, and, as the article is not expensive, it will no doubt be largely sought after.

MALPRACTICE SUITS IN FRANCE.

The Paris correspondent of the *British Medical Journal*, for February 7th, gives an account of an interesting suit for malpractice in which an action was brought by an *officier de santé* against M. Trélat, Professor at the Ecole de Médecine, and M. Delens, of the St. Antoine Hospital. M. Bouyer, the plaintiff, stated his case as follows : In the act of nailing down a box in May, 1883, he slightly injured the left forefinger. He sent for M. Piogey, his neighbor. M. Delens and M. Trélat were called in by M. Piogey, and the plaintiff complained that a number of operations were performed on him, and that he was conducted to a *maison de santé*, and that M. Delens applied undiluted alcohol to his bleeding wound ; that drainage-tubes were applied, and camphor-dressings bandaged on. After six weeks of daily agony, he left the *maison de santé* with a deformed hand. M. Bouyer accused MM. Delens, Trélat, and Piogey of having treated and tortured him against his will, of having injured him by unskilful treatment, and named his damages at 20,000 francs (\$4,000). M. Piogey declared that the plaintiff had a deep wound in the left forefinger, which required constant care day and night ; symptoms of septicæmia soon appeared, and it was necessary to call in surgical assistance ; very serious lymphangitis had set in, and several collections of pus had formed. The patient expressed gratitude for the care taken of him, and never opposed any part of the treatment, otherwise his wishes would have been considered. M. Trélat accepted the responsibility of having M. Bouyer removed to a *maison de santé* ;

his condition required it; he was in an almost hopeless condition, and could not otherwise have had the necessary attention given him. M. Bouyer, the plaintiff, was condemned to pay damages of 3,000 francs (\$600), to each of the three defendants. A few such verdicts in Canada would be hailed with delight by the profession, and would most effectually put a stop to much vexatious litigation.

MEDICAL EXAMINATIONS.—The following is a list of the successful candidates in the various Universities and Colleges in Canada, so far as we have received returns.

COLLEGE OF PHYSICIANS AND SURGEONS, ONT.—FINAL—J. A. Burgess, A. F. Baumann, C. H. Britton, J. D. Courtenay, T. C. Cowan, Margaret A. Corlis, F. W. Cane, H. C. Cunningham, J. A. Couch, F. Campbell, P. E. Doolittle, J. R. Dales, P. A. Dewar, A. W. Dwyer, W. Ewing, D. D. Ellis, D. W. Eberts, J. Ferguson, H. B. Ford, A. Graham, W. J. Gunne, W. S. Harrison, H. J. Hamilton, A. R. Harvie, J. H. Howell, H. H. Hawley, A. R. Hanks, F. Harkin, D. O. R. Jones, J. H. Knight, A. B. Kinsley, C. A. Krick, W. A. Kyle, R. J. Lockhart, W. V. Lynch, A. T. Little, R. Lucy, H. D. Leitch, F. G. Lundy, D. J. Minchin, L. J. Mothersill, J. Marty, W. J. Mitchell, D. C. McLaren, M. C. McGannon, N. McCormack, G. A. Peters, J. J. Paul, W. T. Parry, J. E. Pickard, G. F. Palmer, J. A. Rutherford, H. G. Roberts, Helen E. Reynolds, D. G. Russell, C. F. Snelgrove, J. N. Simmons, A. M. Shaver, S. Scott, J. G. Sutherland, C. E. Stacey, J. A. Stirling, E. A. C. Smith, Wm. Spankie, L. W. Thompson, O. Totten, C. Trow, A. Trudel, J. A. Watson, W. H. Wright, D. J. G. Wishart, E. G. Wood, G. Veitch.

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Botany Prize.—T. A. Clouston, *Practical Anatomy*.—1st year, W. J. Bradley; 2nd year, H. A. Lafleur. *Clinical Medicine*.—H. S. Birkett.

TRINITY MEDICAL COLLEGE, TORONTO.—*Fellowship Degree*.—H. H. Hawley, *Gold Medal*; J. R. Logan, *1st Silver Metal*, A. M. Shaver, *2nd Silver Medal*.—D. C. Throop, C. F. Snellgrove, S. Scott, A. T. Little, *Honors*. N. Allan, A. Baumann, H. S. Bingham, J. A. Couch, F. Campbell, H. J. Caldwell, P. E. Doolittle, P. A. Dewar, A. H. Edmison, T. S. Farrar, A. Graham, H. W. Hoover, E. C. Hood, A. R. Hanks, D. O. R. Jones, R. Lucy, H. D. Leitch, W. V. Lynch, J. Lindsay, R. J. Lockhart, J. J. Paul, W. H. Pepler, H. G. Roberts, C. E. Stacey, J. N. Simmons, O. Totten, J. Watson.

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Scholarships.—First, 1st year's scholarship, G. H. Fere; second, 1st year's scholarship, W. S. Cummings; second year scholarship, John McLurg; third year scholarship, W. H. McKague. Upwards of 80 candidates successfully passed the first year's examination.

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Intermediate Examination.—T. A. Beeman, H. Burdett, Joseph Casselman, C. Collins, N. Coy, A. A. Dame, Miss A. E. Dickson, M. L. Dixon, F. D. Gilligan, G. C. Jack, A. Jamieson, W. M. Mather, P. J. Mellow, E. J. McArdle, E. McLaughlin, A. F. McVity, Miss M. Oliver, T. B. Smith, D. Storms, E. W. Wright. *Primary and Intermediate*.—F. Bruce, J. M. Conerty, S. Cornell, J. G. Creeggan, B.A.; E. J. Donovan, D. E. Foley, F. C. Heath, B.A.; J. J. Lane, D. E. Mundell, J. Mundell, J. M. Shaw. *Hospital Surgeons*.—M. L. Dixon and D. E. Mundell. *Demonstrators of Anatomy*.—E. W. Wright and J. V. Anglin.

VICTORIA UNIVERSITY.—*M. D. C. M.*—J. Barber, A. W. Bigelow, J. A. Burgess, J. R. Dales, J. S. Freebourne, W. A. Goodall, S. M. Hay, A. R. Harvie, L. L. Hooper, H. J. Hamilton, C. J. C. O. Hastings, A. B. Knisley, E. E. King, J. Marty, W. C. McKinnon, H. McGillivray, J. E. Pickard, W. T. Parry, D. Pool, P. P. Park, J. A. Rutherford, J. G. Sutherland, L. G. Smith, W. T. Teasdale, T. Verner, D. M. Williams, H. A. Wright, H. A. Wright, W. H. Wright, G. Simenton.

Primary.—G. M. Brodie, D. B. Cruikshank, J. Caven, F. Campbell, E. Campbell, J. A. Carbert, C. R. Charteris, A. E. Collins, C. R. Cuthbertson, W. G. Dow, W. Dow, D. Dunton, W. H. Fox, E. J. Free, W. G. Glasford, P. H. Galloway, W. R. Gillespie, A. O. Hastings, W. B. Hopkins, R. Hillier, G. Hunt, S. J. Jones, J. Leeming, J. M. McCallum, C. F. Moore, T. M. McFaul, C. F. Nairn, J. F. Orr, J. Rea, P. J. Rice, W. R. Shaw, J. C. Smith, W. B. Thistle, A. F. Tracey, J. C. Vrooman, R. J. Wilson, S. West.

ONTARIO MEDICAL ASSOCIATION.—We desire to draw special attention to the meeting of the Ontario Association, which will be held in London, Ont., on the 3rd and 4th of June. A number of interesting and valuable papers have been promised and every effort is being made by our brethren in London to make the meeting a success, and from what we know of the Western men, we feel assured that nothing will be left undone that can contribute in any way to make the meeting in every respect a success. It will be remembered that this year a new departure will be inaugurated. Instead of the annual reports on medicine, surgery, and obstetrics, the chairmen of the committees respectively will open the discussion on specified subjects, as follows: Medicine,—Dr. Tye, of

Chatham, Diphtheria ; Surgery,—Dr. Powell, of Edgar, Plaster Splints ; Obstetrics,—Dr. Temple, of Toronto, Intra-Uterine Medication. The usual certificates will be issued by the Secretary entitling members to reduced rates by the different railroad lines. We trust that there will be a full attendance of members.

ONTARIO MEDICAL COUNCIL ELECTIONS.—The elections for representatives to the Ontario Medical Council takes place on the 26th inst. Candidates for the Territorial Divisions must receive the nomination of, at least, *ten* registered practitioners resident in such Division, and forward the same to the Returning Officer for the Division on the 5th of May. Voting papers will be issued by the Registrar on the 12th inst. Among the candidates recently brought forward may be mentioned Dr. Jas. Russell, of Binbrook, for the "Burlington and Home" Division, Dr. McDonald, of Hamilton, having retired. Dr. Russell has received a numerous signed requisition, and his election may be safely counted upon. Dr. Orr, of Maple, has also received a large requisition to become a candidate for the King's and Queen's Division, and intends to contest the seat with the old member, Dr. Allison.

ANÆSTHESIA BY THE MIXED METHOD. — This method of producing anæsthesia has been highly spoken of by many leading surgeons. It consists in the administration of a hypodermic injection of morphine and atropine prior to the inhalation of ether or chloroform. The stage of excitement is very slight, anæsthesia occurs more rapidly and the patient rarely vomits. A large dose of bromide of potassium on the evening and morning before the operation, has been found to bring about similar results, and is worthy of further trial. In a few cases in which we have tried it, the good effect has been very wonderful.

APPOINTMENTS *Re* NORTH-WEST REBELLION.—Dr. Bergin, (M.P.,) has been appointed Surgeon-General, and Dr. Roddick, of Montreal, Deputy Surgeon-General ; Hon. Dr. Sullivan, Purveyor-General ; Dr. Orton, M.P., Brigade Surgeon.

HOSPITAL AND AMBULANCE CORPS.—C. M. Douglas, Surgeon-General ; Dr. Bell, of Montreal ; Dr. A. Graveley, of Cornwall, Ont. ; Dr. J. Reddick, of Winchester, Ont. ; Dr. E. Hooper, of

Kingston, Ont. ; Dr. F. H. Powell, of Ottawa, Ont. ; Surgeons. FIELD HOSPITAL, No. 2.—D. H. Casgrain, of Windsor, Ont. ; Surgeon-Major, Dr. R. Tracey, of Belleville, Ont. ; Dr. N. O. Walker, of Toronto, Ont. ; Dr. Francis Murray, of Montreal, Que. ; Dr. Cloutier, of St. Arsene, Que. ; Dr. Phillippe Pelletier, of Quebec ; Surgeons. Dr. Nattress, Surgeon-in-Chief of the Red Cross Corps. Along with these, a staff of medical men, medical students and dressers have gone to the front.

Dr. E. Allen has been appointed Surgeon to the 30th Wellington Battalion of Rifles, and Dr. W. H. Johnson, Assistant Surgeon.

MERCURY AND IRON.—We have seen it stated that iron given with mercury would prevent salivation from the latter. We have tried it many times, giving it in small doses for a long time, without salivating our patients. How much this result depends on the iron given with the mercury we cannot say, but it is a fair presumption that the iron has some effect in preventing the bad effects often accompanying fractional doses of mercury long continued, especially when it is necessary to continue its use for the cure of syphilis.

The *London Medical Times* considers the following the most unfortunate *lapsus calami* which has come under its observation for a long time. The hero of the young lady novelist has succeeded with great difficulty in saving the heroine from falling down the precipitous side of a mountain on which they have lost their way. The heroine has fainted and is apparently lifeless. But to his intense delight the gentleman discovers that the heart still beats "by the pulse in her femoral artery."

DOBELL'S SOLUTION.—The following, which is a very pleasant, soothing, cleansing, and disinfectant wash, is especially recommended in the local treatment of catarrh, laryngitis, &c. :—

R	Acid carbol.		3ss.
	Sod. bicarb,		
	Sod. bibor,	aa.	3j.
	Glycerini,		3j.
	Aquam,	ad.	Oj. M.

SIG.—Apply with a nasal syringe or by insufflation.

COMPOUND FERRIC MIXTURE.—The following which is an excellent tonic and hæmatic, is said to

be used in the Charing Cross Hospital, London, Eng. :—

R Ferri sulph.	grs. xx.
Potas carb.	grs. xxiv.
Sachar, alb.	grs. xlvij.
Aq. cinnam.	℥iv.
Aq. puræ.	ad. ℥viii.

SIG.—One to two tablespoonfuls three times a day.

THE DYSPNŒA OF BRIGHT'S DISEASE.—In a paper read before the Canada Medical Association by Dr. Howard, of Montreal (*Can. Med. & Surg. Jour.*), on the varieties of dyspnœa met with in Bright's disease, he illustrated the following points: (1) That marked dyspnœa may occur in Bright's disease not due to gross lesions in the lungs, pleura, or heart, such as inflammation or œdema of the lungs, hydrothorax, or pleurisy with effusion, endoor peri-carditis, or valvular disease. (2) That it may be continuous dyspnœa, or of a paroxysmal character, resembling ordinary spasmodic asthma; and that these types may occur in the same case, although in his experience, the continued variety is more frequent than the asthmatic. (3) That these forms of dyspnœa may occur as the prominent symptoms of renal disease, and their origin may escape recognition if the urine be not carefully examined, as well as the heart and pulse. (4) That Cheyne-Stokes respiration is often a symptom of Bright's disease, and that it obtains in both acute parenchymatous and in chronic interstitial nephritis. (5) That while usually an evidence that the fatal issue is near at hand, it may occur in a chronic form, and may occur for weeks, perhaps even for years. (6) That these several forms of dyspnœa just mentioned are very probably due to that defective renal elimination called uræmia. (7) That in the acute forms of Bright's disease, serious or fatal dyspnœa sometimes, but rarely, occurs in connection with effusion into the submucous membrane of the larynx (œdema glottidis).

LOCAL APPLICATION FOR PILES.

R Pul. opii.	
“ Aloes	aa grs. v.
Ext. Hamamelis,	℥j.
Cosmoline,	℥j. M.

SIG.—Sponge the parts with warm water and apply after each defecation.

PARALDEHYDE IN DELIRIUM TREMENS.—This new remedy has been found successful in the treatment of delirium tremens, after the failure of potassium bromide, valerian, hyoscyamus and morphine to produce sleep. This agent is claimed to be a hypnotic, producing a perfectly natural sleep of from two to six hours' duration, from which the patient awakens without any sense of distress, headache, dulness or nausea. It may be administered in the form of an elixir, two drachms of the drug being dissolved in an ounce of simple elixir and a tablespoonful administered, to be repeated when necessary.

BRITISH DIPLOMAS.—Drs. Davidson and Furrer, (Trinity), have been admitted to the M.R.C.S., Eng. Dr. W. A. Goodall (Toronto) has obtained the License of the King's and Queen's College of Physicians, Dublin.

We are very much pained to learn of the death of Private Ferguson, son of Dr. R. B. Ferguson, of Winnipeg, in the Fish Creek battle. The Dr. has our deepest sympathies in his severe family affliction.

CORONER.—Dr. J. M. Cotton has been appointed coroner for the County of York, Ont., and Dr. G. Schmidt for the County of Waterloo.

The death of Dr. Jas. L. Little, of New York, is recorded in our American exchanges.

Notes, Queries and Replies.

To the Editor of the "CANADA LANCET."

SIR.—If your correspondent, who asks for experience regarding the use of picrotoxine as a remedy for sweating in phthisis, will refer to McKesson & Robbins "Formula Book," he will find some remarks which influenced me in selecting this drug. I have employed it in cases of sweating from various causes and am very much pleased with the result. Yours truly,

J. H. BURNS, M. D.

Toronto, March 31st, 1885.

To the Editor of the CANADA LANCET.

SIR,—The following question was given at the late Council examination: What poison can a woman take to poison her child, without injuring herself, through her milk, and how can you detect

it by *post mortem* examination of child after death?

Will some one please answer in next LANCET?

Yours respectfully,

L. J. MOTHERSILL.

Tuscarora, April 28, 1885.

Books and Pamphlets.

INSANITY AND ALLIED NEUROSES; PRACTICAL AND CLINICAL, by George H. Savage, M.D., M.R., C.P. Physician and Superintendent of Bethlehem Royal Hospital, &c. Published by Henry Lea's Son & Co., Philadelphia.

The American reproducers of this work have probably long ago learned the fact that a large book is, in the eye of the student of any branch of medicine, a large evil. They have therefore contrived to squeeze into this unpretending little octavo, on fine paper and in clear type, a quantity of most instructive solid matter, which might not inexcusably have been made to fill one of twice the size. Never has it been our good fortune to rise from the perusal of any work on insanity with more thorough gratification than we have realized throughout all its pages. It was our intention to present to the readers of the LANCET some extracts from which they might be enabled to form an anticipative opinion of the real merits of the book; and with this view we made notings of such passages as appeared to us most saliently instructive, but before we had got over half the pages, these markings had become so numerous that we have reluctantly felt constrained to relinquish our purpose.

The book is presented as a "Manual for Practitioners and Students." Every practitioner of medicine is, or ought to be, a student of insanity; therefore it would not have at all derogated from the dignity of the former to have passed them over unnamed. It is sincerely to be hoped that those of ripe knowledge and prolonged observance will not allow themselves to be distanced in the field of alienism by their juniors. A little money devoted to the purchase, and a very little daily time to the study of Dr Savage's plain and modest treatise, will not fail to prove profitable investments. But whatever may be the appreciation in which it may be held by the general profession, it is sure to be highly valued by the entire body of

alienistic and neuropathic specialists. Every man who has had any lengthened experience in psychiatry, and has loved his work, will feel, in reading Dr. Savage's graphic and succinct description of cases, as if he had been erewhile walking arm in arm with the author, for years, through the wards of his own asylum; and the retired veteran will have displayed before him a living panorama of mental scenes and shadings, which must revive his remembrance of many anxious and many pleasant days in his past life,—scenes and shadings which lapse of years may have begun to enshroud in the gloom of clouded remembrance, but whose reproduction he will contemplate with a kindred gratification to that of the tired pilgrim on his return to his youthful home.

We cannot but commend Dr. Savage's book to every member of the medical profession, and to every student who aspires to the possession of a sound practical knowledge of mental disorders. It is quite probable that if more attention were given to this department of medical science, the public would be relieved from witnessing many of those scenes of professional conflict in courts of law, which are the opprobria of our profession.

THE POPULAR SCIENCE MONTHLY FORMAY, 1885.
New York: D. Appleton & Co. Fifty cents a number, \$5 a year.

The first paper, "Our Recent Debts to Vivisection," by William W. Keen, M. D., is a graphic account of the benefits that have been conferred upon humanity during the last quarter of a century, by means of experiments on animals. There is no strained construction in the argument, and the numerous examples given cannot easily be explained away. Dr. Max von Pettenkofer's valuable and timely papers on "Cholera" end in this number, with the fourth of the series, which is mainly devoted to the subject of prevention. "A Scientific View of the Coal Question," by G. Gore; and "Training in Ethical Science," by Mr. H. H. Curtis, are able articles. "The Nervous System and Consciousness," by Professor W. R. Benedict, illustrated, and "Arctic Exploration and its Object," by Dr. Franz Boas, are both good papers in their respective departments. There is also an article by Professor Tyndall, describing the patient labor, the ingenious methods, and the grand results of "Pasteur's Researches in Germ-Life."

THE EAR, Its Anatomy, Physiology and Diseases, a Practical Treatise for the use of Medical Students and Practitioners. By Chas. H. Burnett, A.M., M.D., Professor of Otology in the Philadelphia Polyclinic and College for Graduates in Medicine, etc. With 100 illustrations. Second edition, revised and rewritten. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

The above work will be cordially received by the profession, especially those members who have become acquainted with the author through a perusal of the first edition, or in attendance upon his lectures on this subject. His style is clear and concise, and his methods attractive. The work of revision has been carefully done, and much new matter, rendered necessary by the progress of the science, has been added. The author in the outset gives a description of the anatomy of the parts, which is followed up by a description of the instruments used, and how to handle them, and concludes with a clinical history of the various diseases and their appropriate treatment. The work will be found very useful to those desirous of acquiring a knowledge of the diseases of the ear.

THE SCIENCE AND ART OF SURGERY. By John Eric Erichsen, F. R. S., LL., D., F. R. C. S., Emeritus Professor of Surgery in University College, etc. Eighth Edition Revised and Edited by M. Beck, M. B., Lond., F. R. C. S., Eng. Prof. of Clinical Surgery in University College, London. With 984 Engravings on Wood. Vol. II. Philadelphia: Lea Bros. & Co. Toronto: Hart & Co.

We have already noticed with comments the first volume of this classic work on surgery, and it only remains at present to notice the issue of the second volume. It embraces a consideration of those affections, not included in the first volume, and contains an appendix on corrosive sublimate as an antiseptic. We cannot speak too highly of this excellent work. It represents the most advanced and settled views in regard to the science of surgery, and will ever be found a faithful guide and conseller in practice.

KIRKE'S HAND-BOOK OF PHYSIOLOGY. By W. Morratt Baker, F. R. C. S. Lecturer on Physiology at St. Bartholomew's Hospital; and Vincent D. Harris, M. D., London, Demonstrator of Physiology at St. Bartholomew's Hospital. Eleventh edition with nearly 500 illustrations. Vols. I. and II. New York: Wm. Wood & Co.

The above work constitutes the February and

March Nos., of Wood's Library of Standard Medical Authors, and will no doubt be hailed with satisfaction by the subscribers to this "Library." Kirke's Physiology is so well known to the profession that an extended notice would be quite superfluous; the fact that it has reached the eleventh volume speaks for itself. All the recent advances in the science have been incorporated in the work so as to bring it fully abreast of the times.

AN INTRODUCTION TO PATHOLOGY AND MORBID ANATOMY. By T. Henry Greene, M.D., Lond., F. R. C. P., Lecturer on Pathology at Charing Cross Medical School. Fifth American and sixth revised and enlarged English edition, with one hundred and fifty engravings. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

This able and instructive work is well known to the profession, and the edition before us fairly represents the status of this important branch of medical study. It is a lamentable fact that too little attention is paid to pathology and its sister science physiology by the majority of medical practitioners on this side of the Atlantic. A careful perusal of such a work as this, however, cannot fail to arouse an interest in the study of this much-neglected branch of medical science.

BERLIN AS A MEDICAL CENTRE, by H. R. Bigelow, M.D., Washington, D.C.

The above work will be issued by the New England Publishing Co., Sandy Hook, Conn., during the month of May. It will be a complete and accurate medical guide to Berlin, giving instructions in reference to board, clinics, lectures, expenses, etc., and all information that will be necessary for the medical student abroad. The price will be \$2.

Births, Marriages and Deaths.

On the 15th ult., J. T. Small, M.D., M.R.C.S. Eng., of Toronto, aged 63 years.

On the 29th March, D. A. Livingstone, M.D., of St. Chrysostome, Que., aged 30 years.

On the 10th ult., J. McCurdy, M.D., of Chatham, N.B., aged 42 years.

On the 11th ult., D. Burnet, M.D., of Cobourg, aged 40 years.

On the 23rd March Dr. Thomas Tanner, M.D., of Holstein Ont., aged 64 years.

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CRITICISM AND NEWS.

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Original Communications.

ON THE BROMIDES IN EPILEPSY.

BY PROF. G. LEE, HOTEL DIEU (*Revista Argentina*).

Translated from the Spanish by J. Workman, M.D.,
Toronto.

What part of the therapeutic action belongs to the potassium, and what to the bromine? The action of the bromide of potassium on the organism has passed through strange vicissitudes. In the outset all the effects were ascribed to the potassa; after the labors of Traube the effects of the potassic salts became known, particularly of the nitrate on the heart, which, after a short period of excitement, suffered a certain degree of depression, with diminished blood pressure; and it was hence concluded that all the salts of potass, whatever might be the acid or the metalloid, possess true therapeutic properties; but experience soon showed the complete inertia of the chloride, the nitrate and the iodide of potassium in the treatment of epilepsy; it was then proved that potass in general, in whatever dose or combination, did not possess the least therapeutic influence over epilepsy.

This was the second phase of the bromide, diametrically opposite to the first. It is necessary to divide and separate the physiological action into two parts; on the one side, to discover its effects on the brain, the medulla and the skin, which represents its special nature; and, on the other side, its effects on the circulation, the respiration and the temperature, which would be those of its common or alkaline nature.

Here now we have the potass pretty well demonetised; but the physiologist limits himself to a few hours of observation on some animal whose intelligence he cannot penetrate, whilst the clinicist sees and follows the cerebro-spinal phenomena for a long time, and does not hesitate to recognize

the pre-eminence of clinical medicine; it is this which teaches the therapeutic properties, and above all the cerebral action, of the bromides in general, and of the bromide of potassium in particular.

The latest investigations by Kroy, on man, show clearly that all the virtue resides in the bromine; yet, on the contrary, on animals, the excessive proportion of 67 per cent. of bromine against 33 of potass in the bromide passes, or may pass, through without producing the least effect.

The third vicissitude undergone by the bromide of potassium, not only despoiled it of its curative property, but transformed its action on the heart into a real intoxication of the organ; in this turn the disadvantages of bromism were imputed to the potass, which was regarded as decidedly lethal; and it was believed that it was merely necessary to replace it by some other alkaline base, in order to get clear of all the dangers of a drug which is prescribed through months and years. This gave birth to the bromide of sodium, the bromide of ammonium, and lastly to the mixture of these two with the inevitable bromide of potassium. The polybromides, perhaps for the very reason that their complex effects are unknown, are to-day much employed, as a consequence of the potassophobia; yet it is enough to know that the habitual dose of six grams of the bromide of potassium introduces into the system only two grams of potass. How has it happened that such a dose, taken into the stomach, has never produced the least inconvenience?

The ashes of alimentive vegetables represent 3 to 4 % of their entire mass; the mineral residues of the potato contain 60 % of potass, that is to say, more than a grain and a half for every 100 grams of the tuber, and yet neither its sedative virtue, nor the danger of its use, has ever been suspected. Lastly, it is easy to prove that in order to obtain the equivalent effects of 5 grams of the bromide of potassium, the dose of the bromide of sodium must be raised to 10 or 15 grams. So, in order to avoid a very uncertain danger, we inevitably, by this excessive dose of the bromine, fall into the grave inconveniences of bromism, as is proved by the convulsions caused by injections of the bromide of sodium, just as by those of the bromide of potassium, into the blood of animals. Rochefonte has demonstrated this by his investigations in my laboratory. The bromide of am-

monium is still more exciting, so that the three united salts do not present any advantage over the potassic bromide, which figures for one-third in the mixture styled the polybromide.

Absorption and Dose—Effects of the Bromide on the Eliminant Organs—Slight Bromism of the Respiratory Mucous Membrane, and of the Skin.

The bromide is readily and promptly absorbed by all the mucous membranes; after some minutes it appears in the urine, and is eliminated almost in totality in two or three days; hence the imperious necessity of continuing the treatment without interruption; at the most it may be suspended for a day at a certain time, or the dose may be decreased; but to suppress it is dangerous. I have seen patients who, from having neglected the use of the medicine for a few days, have been attacked with convulsive fits after a quietude of eight months or a year.

The bromide is eliminated by the kidneys in great part, very little by the salivary glands, and still less by the stomach; and these organs are, as we shall show, but little impressed by it. The same fact does not apply to the respiratory mucous linings, which also serve as a means of passage to the bromide; they are profoundly altered in its elimination. The pharyngeal mucous membrane becomes the seat of a pricking, painful sensation, and of a well-pronounced paleness, due to the local ischæmia; after the doses have been raised to five or six grams, the velum palati is anæsthetised more or less completely. Voisin, who has closely studied the effects of the bromide, advises that it be taken to the extent of 10 or 12 grams, that is to the production of insensibility of the isthmus of the fauces, which would be the sign of saturation; but there are such individual differences in this respect that we should run the risk of poisoning the patient before this indication of brominal impregnation might appear, which is, so to say, *en passant*, perfectly useless. Voillez has spoken of directly anæsthetising the fauces with gargles strongly bromidised, with the view of restraining the cough as well as the vomitings that follow the kinks in whooping-cough and phthisis; this mode of extinguishing the impressions of sensibility, which provoke the reflex acts of coughing, has had no good result; it is, in fact, very difficult to prolong the contact of the bromide

with the pharyngeal wall until we effect the loss of sensibility of the mucous membrane. The bromide does not act until after the gastric absorption, and the commencement of elimination of the bromide by the mucous membranes. For the same reasons we do not obtain, unless with difficulty, insensibility of the mucous membrane of the larynx from the mere action of bromidal sprays; in order to extinguish the sensibility of the larynx, as well as of the pharynx, it is necessary to imitate the process of Voisin, and saturate the patient; but to push to this extremity is very dangerous.

The bronchii are frequently the seat of a sharp irritation, which results precisely from the elimination of the bromide by the secretory glands, when it is presented as well as in the bronchial mucosa, in saturated epileptus; this bromic bronchitis, which is introduced by a short, irresistible cough, dry at first, and followed by a slight expectoration, is one of the most grave obstacles to the continuous treatment which epilepsy demands; I had believed it well to quiet this cough, which occurs chiefly in the night, by conjoining atropia with the morphia, but the result of the combination was generally harmful: either the cough did not cease, and it became necessary to interrupt the treatment, and even in three of the most grave cases to give up all medication; or, though the narcotics succeeded in calming the cough, yet they nullified the effects of the bromide; it appeared to me, however, that the tincture of the root of aconite, in doses of one grain per day, presented some advantages over the other narcotics, and above all over the expectorants (such as antimony, sulphur, turpentine), which only aggravate the evil. What, then, after these facts, which are so easily proved, are we to think of the prescription, in obedience to certain precepts, of the bromide in bronchial irritations?

I do not know of any sort of cough, whether of whooping-cough, of hysteria, or still less of tuberculosis, in which relief is derived from the bromide; the very contrary is the result. It must be stated that these prejudicial effects are observed even with the moderate doses of three grams; I have seen a young epileptic girl who could never exceed the dose of a gram and a half. What, then, would have been the result of large doses? In studying the grave bromism we shall find pulmonary inflammations resulting from the abuse of

bromine ; I could cite three unfortunate and convincing examples.

In the skin, as in the bronchii, both a slight and a grave bromism are produced. It is very rare that the bromide, which is eliminated by the integument during life, or, in fatal cases, is found in the sudoriferous glands and likewise in the sebaceous follicles, does not, from the first day, produce a very evident effect on both layers of the skin ; even from the first day, in small doses, it produces acnes, which are seated preferentially on the face or the breasts ; two or three grams suffice to bring this eruption, and it may be generalised and become numerous, so as to prevent the continuation of the treatment. In these cases I have always employed, with good results, arsenic in addition to the bromide ; of late it has been proposed to use the bromide of arsenic, but it offers no advantage over the bromide of potass., with the addition of 10 or 12 drops daily of the solution of Fowler.

The kidneys are not changed either in structure or function in the elimination of the bromide ; they do not secrete a larger quantity of urine than they do in the normal state, consequently the bromide cannot be regarded as a diuretic. Neither does the bromide change the composition of the urine ; we merely know that it contains more chloride of potass, which leads to the supposition that the bromine leaves its base and that it joins with the sodium in the blood, forming the bromide of this substance ; this would be another proof that it is the bromine alone which acts, whatever may be the alkaline base ; we shall see presently whether it acts on the oxidations, and consequently on the quantity of uric acid and urea eliminated in the urine.

The salivary glands eliminate the bromide with less facility than they do the iodide, but if the dose be increased a notable quantity is found mixed in the saliva ; at the same time there is manifested, without doubt from the reflex action produced by the bromine on the maxillary nerves, a salivation which is frequently abundant and dangerous, and contributes not a little to the enfeeblement of the patients.

The gastro-intestinal mucous lining seems to be but little impressed by the bromide ; it causes gastric pains at the moment of its introduction into the stomach, but these may be avoided or calmed by diluting the salt with a sufficient quan-

tity of water ; the majority of patients, especially if they take the medicine in solution in their aliments, experience no change in the gastro-intestinal functions, nor any painful sensation, dyspepsia or constipation. This functional immunity leads us to suppose that the medicine is not eliminated by the digestive mucous linings, as iodine is. The secretory organs most briskly attacked are, as is seen, the respiratory mucous membrane, on the one part, and the integument on the other. This is what constitutes the first degree of bromism, as indicated by Huchard.

The Bromide is a Vaso-Constrictor-Medicament, that is to say, an Anemiant.

After having shown the bromine as acting solely by reason of its two constituent elements, and having pointed out the first degree of bromism of the skin and the bronchii, we now come to define the true and useful properties of the bromide. The principal are two ; one proceeds from the vaso-constrictor effects, that is to say, from its anemiant action ; the other consists in its depressing action over the general reflex power, and more still over the excitability of the general cortex (? cerebral).

The faculty possessed by certain energetic medicines, of acting on the vessels through the intervention of the vaso-motor-centre, has long been established ; some provoke contractions of the vascular muscles ; such are the bromide of potassium and the ergot of rye ; others cause active dilatation of the arterioles, as we showed, conjointly with Meuriot, 20 years ago ; others paralyze the vascular tunics, as the nitrates of amyl and soda ; with the last named we may include curare. It is very remarkable that these medicaments are precisely those which have been prized in the treatments of epilepsy, and often for curious reasons ; for example, the bromide to combat the genital excitation ; belladonna to diminish the spasms ; curare to provoke a curative fever, and the nitrates as energetic and rapid sedatives. In reality, if we abandon the false data of empiricism, and seek for the scientific solution of this complex problem, therapeutics and experimentation fall into accord, and we easily comprehend how so important a role is acted by these vascular-medicaments, and why they deserve to be taken into consideration, despite their qualities, most diametrically opposite from the point of view of their vaso-motor action.

The bromide is undoubtedly an anemiant; Sakokoski, Samola, Sezutzki and all the experimentors are unanimous on this point. By exciting, in the vaso-motor centre the constrictor nerves, the field of the circulation becomes restricted, particularly that of the bulb and the encephalon; it is known that anemia of the medulla oblongata is an experimental character of epilepsy. How are we to reconcile with this fact the beneficial action of the bromide? The reply is easy. The epileptic fit begins with anemia, resulting from the excitation of the vaso-constrictor nerves; against this transitory phase the bromide is powerless, but the fit continues and it ends in a hyperæmic process which provokes vaso-dilatation. It is by its antagonistic and vaso-constrictor action that the efficacy of the bromide is explained; but this is not all: it possesses, as we shall show, a strongly depressive power, or as we might say, a destructive one, over the reflex excitability, alike over the brain cortex and the bulb; consequently it impedes the attack and may also restrain the evolution of the disease.

Well now, is there a single vascular medicament that can be compared to it? Not one. The ergot of rye, which is a vaso-constrictor, visibly excites the reflex power of the medulla; belladonna, which is a vaso-dilator, excites the reflex excitability; as to curare it meets no requirement whatever, by paralyzing the vessels it operates lethally; as to the nitrites of amyl and soda, they have but an ephemeral effect on the fit and the vertigo, and they are, so to say, impracticable because of their toxic action. It now remains for us only to prove the depressing property of the bromide on the excito-motor system.

The Bromide Represses the Exaggerated Excito-motility in Epilepsy.

Hurette and Rames, in 1850, recognized in the bromide the anti-excito-motor property which readily explains the insensibility of the pharyngolaryngeal mucous lining, under the influence of large doses. Laborde has studied this special faculty, which acts also on the genital innervations. Since my first investigations in 1858, when my attention as well as that of Brown-Sequard, was given to the hypnotic, or better to say the sedative effects, which in no respect resemble narcotism, and consist above all in a diminution of the impressionability by external influ-

ences, the bromide, taken to the extent of three or four grams nightly, has procured the most tranquil sleep, leaving no vestige of heaviness or pain in the head, such as follow the action of opium. I have utilised this sedative potency of the bromides from the outset of the megrim, which aborts, or is in a certain way shortened.

All these clinical facts ought to leave not the least doubt; an experimentation of late by Albestoni, lauds a physiological proof that seems to me irrefutable, and applies marvellously to epilepsies of cortical origin. By electrising the cerebral cortex, after laying it bare with the trephine, Albestoni produced partial, and often general convulsions; when he previously administered to the animal under experiment two or three grams of the bromide, the electro-excitability of the cortex diminished considerably, and so much the more the longer the action of the bromide was kept up. The medicine, in a certain dose, impedes the electricity in producing convulsions; it appears that resistances are formed in the bromidised encephalon, or this propagation of the excitation to the psycho-motor-centres is prevented. There is then produced a true excito-motor-paralysis, which is all the more curious as the voluntary movements continue unaffected. In proportion to the suppression of the bromide, this state of the encephalon disappears; it recovers its prior excitability, and the electric excitations acquire their convulsive potency.

It is impossible, in this ingenious experiment, to ignore the proof of the depressing power of the bromide over the excitability of the brain. In comparison, Albestoni met with nothing analagous in belladonna or atropia, nor in curare; all these poisons increased or exaggerated the reflex sensibility; nothing further then is to be expected. The bromide is the unique vascular medicine, and at the same time a real anti-excito-motor.

Grave Bromism.

It now remains for us to point out the inconveniences, frequently the dangers, of an intense and continued bromidation.

When it is prescribed without the precautions we have indicated, permanently in six grams or more, the patient is exposed to grave alterations in the skin, the mucous membranes—principally the respiratory—failure in the heart's action and

the circulation, and general depression of the encephalic system. I thus summarize the grave bromism: The mouth acquires a foul odor, the gums become pale, and an incorrigible salivation is established, which rapidly saps the powers of the patient. The heart acts slowly and weakly; in doses of 15 grams daily its beats are reduced to half the normal number; by prolonging the administration of these doses, the intra-cardiac nerves and the cardiac muscle itself, may suffer a commencement of paralyzation. At the same time the intravascular pressure is weakened, and the temperature may descend. What is still more grave is the deterioration, or general impairment, produced by a well-marked elimination of phosphoric acid and urea. The peripheral circulation feels this loss of the general forces and of that of the heart; the patient acquires an extreme paleness, with brownish tints, or the extremities even assume a livid hue, which indicates sanguineous extases. The respiration is, in its turn, attacked; besides the cough and the bromidic bronchitis, which are frequent and often severe, I have seen a mortal pneumonia, which I attributed to the bromide, three times produced; one of these cases was followed up by my colleague and friend Peter; it was that of a girl, with deformity of the cranium, who was attacked by epilepsy; the second case was also of a girl who was an idiot; she died of pneumonia with grave alterations of the skin; the third patient was a boy of four years, who took five grams of the bromide prescribed by a physician who treated him by correspondence.

It is, finally, necessary to signalize that excessive debility which amounts even to impossibility to walk, and to hold the trunk erect, a sort of drunkenness, with general insensibility, somnolence, expression of horror, depression of memory, involuntary emission of urine. As soon as any of these manifestations are presented, all treatment should be suspended for a longer or shorter time, and the doses that have provoked the bromism in the skin, the respiratory or the nervous system, must not be renewed.

Physiological Rules of Bromidation.

It is not enough that we prescribe the bromide even in regular moderate doses, sufficient to obtain a favorable, and above all a definitive, result; it is important to observe all the rules taught by

physiology, for the diminution of reflex excitability. I described these in 1868; they may be found clearly formulated in those valuable annotations which my friend and co-worker, Labadie-Lagrave, has added to the book of Hammond, of which they constitute the complement, and are at the same time an indispensable commentary. I quote textually thus: "The efficacy of the bromide depends almost exclusively on the depressing action which it exhibits over the reflex power of the medulla oblongata and spinalis. Everything that may counterbalance this action, everything that may awaken the morbid excitability of the nervous centres, must be severely proscribed. Epileptics must be forbidden alcoholic drinks, wine, beer, or gaseous waters; alcohol and carbolic acid singularly arouse the faculties of the excito-motor and bulbo-medullary systems. Coffee and tea usually have the same result. The patients must abstain from smoking; the nicotine, by exaggerating (?) the vascular action of the bromide, and in a certain way tetanising the arterioles of the nervous centres, seems to extinguish the useful effects of the bromide. Violent gymnastics, the various hydropathic practices, particularly sea baths and douches, have a very fatal action, by provoking return of the fits. The same result follows physical pains, moral emotions, and genescic excitations."

I forbid all active medication, such as purgatives, emetics, revulsives, cauteries, etc., which are capable of producing a great disturbance of the organism; with still greater reason is it necessary strongly to prohibit abstractions of blood.

Auxiliary Means.

The auxiliary means which I have been enabled to approve of, are iron, especially the tartrate of potass and iron, one gram daily; arsenic under the form of Fowler's solution, 12 drops daily; quinia in extract and the sulphate of quinine; lastly, cod liver oil, and above all oxygenation by permanent residence in the country; such are the strengthening medicaments destined to combat the dangers of bromism and the weakening of the nervous system.

Bodily exercise in the open air, without fatigue, moderate intellectual work, well directed, constitute the most important auxiliaries—let these be attended to above all in controlling the education

of children; the due functioning of the brain hinders it from atrophying. It is to be kept in mind that functional debilitation of the brain leads to exaltation of the medullo-bulbar system, and therefore tends to exaggeration of the excitomotor power, that is to say, to the return of the epileptic fits.

The bromide, in medium doses of five to six grams, rather exalts than depresses the intellectual powers, which are generally intact between the fits, often indeed much developed, as I have seen in numerous examples; history records great geniuses of this class, as Cæsar, Mahomet and Petrarch, who were epileptics.

General Results of Bromidation in the Various Epilepsies, and their Principal Manifestations.

1st. Of 150 epileptics treated by me in 25 years, 90 of whom have been closely observed, during two years and over, the majority began the treatment in ages between 10 years and 30; the commencement of the disease dated back to various epochs; among those who had not reached ten, or who had passed 30, I cite the following: a boy of two years, who had never been able to take more than 25 centigrams of bromide per day, without falling into a profound prostration; he remained without treatment during four years; afterwards he took the bromide, and the fits disappeared. In an analogous case, in a boy of three years, the dose of a gram daily continued for two years, brought about, after some periods of physical depression, a complete cure, and he has continued free for many years. Amongst those over 30 years old, I mention one patient of 52 years, whose mother was an epileptic; his attacks had lasted over 20 years; he marvellously recovered, and his children are exempt from the disease.

2nd. Among these 150 epileptics, I count 10 cases due to deformity of the cranium with idiocy; not one of these was cured; three died after some alternations of relief; death in two of the three was due to bromidic pneumonia, and in the third to ulcerations of the skin, with cachexia. In the remaining 140 cases, I have noted three of vertigo without fits; in one of these the disease has resisted all treatment; it was that of a well-formed girl, very intelligent, who had 40 vertigoes daily; all the means employed were useless; the bad result of the bromide is explicable by the cir-

cumstance that it is much less operative in cortical than in vaso-motor epilepsy. (?)

3rd. All the rest of the patients had convulsive seizures, some of which were preceded by asthma (*asma*, ? *aura*). In the great majority, whatever had been the previous number of the attacks, the disease was ameliorated in this way: the crises disappeared, not to return, unless rarely and far apart, and always so attenuated that the patients did not fall, nor lose consciousness, or have convulsions. Two-thirds of the patients in this category were followed and observed for years; 12 recovered completely, and were able to leave off all treatment. All those who did not recover had suffered the effects of bromism up to the point of being forced to give up the treatment, for a certain time at least; three young girls and a boy of four years had bromic disturbances of the bronchii, so persistent that I was obliged to renounce the bromide, or arrest its affects with aconite. In five other instances I had to contend with bromism of the skin, which became the seat of general eruptions that were often confluent; here the addition of arsenic almost always succeeded in removing this complication. When these difficulties were surmounted, I had nothing to fear, unless errors of hygiene, regimen and drink; unseasonable or too long bathing, and above all hydrotherapy, which hardly ever failed to produce disastrous effects.

4th. The effects of the treatment on the brain have been almost always favorable. Bennett, who has published a series of statistics in this relation, proves the perfect maintenance of the general and the intellectual powers in at least three-fourths of the cases submitted to bromidation, throughout five years. When the intellect becomes weak, the fact is always attributed to the treatment; it is easier and less humiliating to the relatives to fall upon this alternative than to admit the real cause, which is the disease, invading and degrading the brain as it progresses.

In fine, the majority of the organs remain intact; their functioning continues normal, and bromidation, well directed, with observance of the precautions indicated, may produce a definitive cure.

Luton of Rheims, and Verneuil of Paris recommend strychnia in hepatic affections of alcoholic origin.—*L'Union Medicale*.

REPORT ON SURGERY*

BY W. BURT, M.D., PARIS, ONT.

NERVE-STRETCHING.

The following summary, gleaned from the "Bradshawe" lecture, delivered by John Marshall in December last, gives us the principal information now in our possession in reference to this recent operation. In the operation of nerve-stretching there is a palpable stretching. Nerves nearer to the spinal cord are rather more extensible than those at a distance. This may be owing to the relatively less thickness of the sheath. The distant nerves are smaller, but they are probably better protected. The nerves of the upper limb are more extensible than those of the lower limb, probably for the same reason that the nerves of the lower limb are better protected by sheaths; for we must recognize that it is the sheath that bears the strain when we pull upon a nerve. After a nerve is stretched it recoils. One observer states that after stretching a nerve it recoiled one-fortieth of its length. The safe therapeutic weight varies from about 1 lb. up to 30 lbs. The former, for the smaller nerves, as the mental, the latter for the great sciatic. When nerves are stretched, the epineurium and perineurium lose their wavy appearances and become straightened; the natural segmentation of the medullary sheath gives way to an irregular breaking up. Sometimes the tubuli break, and still more rarely the axis cylinder gives way. After this the nerve degenerates, and after the whole mass of nerve has become disintegrated, restorative changes follow and its function is gradually restored. Sensation and motion are the first to be extinguished, and lastly reflex action.

Effects on the Cord.—Practically there is no stretching mechanical effect propagated through the roots of the nerves to the spinal cord. In the sciatic, the stretching effect passes to the sciatic plexus, passes to the roots of the nerves, where it must disturb the spinal ganglia on the posterior roots and it must disturb the dura mater. It may by disturbing the dura mater shake the cord a little through the ligamentum denticulatum on either side, but we find no change of tension in the intra-spinal or intra-meningeal part of the nerve, and no movement in the cord. The effects are

bilateral. The effect of stretching nerves on one side passes over in various degrees to the other side of the nervous system.

Therapeutics.—Specially successful in peripheral paralysis and neuralgias of all kinds; less so in tetanus; still less so in epilepsy and tabes. In the case of neuralgias, the presence of *nervi nervorum* is assumed, and that it is through the rupture of these that the pain is got rid of. Nerve-stretching is said to act, not only by rupturing the assumed *nervi nervorum*, but in other cases by partially numbing or paralyzing the internal tubules, arresting their function for a time, or, further, by indirect effects on nerve centres. In tabes and central neuralgias it is said to act by producing some indirect effect upon central nerve elements through trophic changes, probably induced by the disturbance of vasi-motor action.

The operation is performed, with one exception, by exposing the nerve, lifting it with the thumb and finger until a *palpable* stretching is produced. Sufficient force is to be used until the nerve sensibly yields to your traction—until you feel an internal creeping movement in the particles of the nerve, of the sheath, no doubt; until you feel a certain attrition and vibration going on—and you must educate yourself to that, and then you will be safe. The thumb and finger can stretch with a force equal to a weight of 30 lbs., the amount said to be sufficient for the largest diseased nerve, the sciatic. Stretch both ways for neuralgia. It is of less consequence to stretch from the extremities in tabes; it is essential to stretch from the trunk or body. A continued even force, firm and resolute, is desirable. Without cutting, Sayre reports, a positive improvement in tabes in thirteen out of fifteen cases, from the use of his suspensory apparatus, for ten minutes three times a week, the sciatic can be well stretched by forced flexion of the lower limb. It appears from the above that the cutting operation should not be resorted to for tabes. The dangers are those of chloroform, thrombus, pyæmia, and disease of the spinal cord, set up by the operation.

NEUROTOMY.

To the above collection of material in reference to nerve-stretching, I might add the result of neurotomy in a recent fatal case of traumatic tetanus. Patient had the last phalanx of the left

*Read before the Ontario Medical Association.

ring-finger crushed, splitting the bone into lateral halves. As much of the phalanx was removed as was thought would insure ready healing. When the finger was about healed he complained of not feeling well, but kept at work. On the second day of illness, found jaws closed and spasms coming on, causing him to rest on his abdomen and chest. On the third day, temp. 102; neurotomy of the ulnar, median and radial nerves was performed, completely isolating the finger. The joint was removed at the same time. Chloral and potass bromide were used. By evening the mouth could be opened with the greatest freedom, and only during the spasms would it shut violently. The spasms, however, continued; the temperature gradually rose, and on the third day after the operation death ensued. The only direct effect of the operation, in this case, was the relaxation of the muscles of the jaw. The reason of the delay in operating in this case, was the almost total absence of the spasms for a time, under the use of the chloral and bromide mixture. They however returned violently, although the medicine was kept up with the result above stated. There appears no doubt that it is through the medium of the nervous system that the blood changes if any are induced. I have no doubt, however, that the pathological changes take place first in the nervous system, whether the disease be idiopathic or traumatic.

ACCIDENTS OF GAMES.

Foot ball.—I will simply quote a few paragraphs that should prevent a Canadian adopting the rude and barbarous sport of the United Empire. I refer to the Rugby game. What is said by surgeons in England against foot ball, is aimed chiefly at the Rugby rules. If these rules are entirely done away with, or even modified, I believe it will be because of their unanimous condemnation by the profession. Surely unavoidable accidents happen only too frequently without playing according to rules, the inherent nature of which will lead to serious injuries. A. Williamson, manager of the Northern Accident Insurance Co., states in the *Lancet*, "that he had been compelled to decline renewing all special policies covering foot ball and bicycling accidents only, as our experience went to show that these risks, as a special class, were most unprofitable." The accidents attending other sports cannot be numerous or dangerous, for he states, "all our

general accident policies cover these risks (foot ball and bicycling) without extra premium." The *Lancet* states that our often repeated assertion that accidents arising from foot ball, as at present played, are more numerous than those occasioned by any other athletic exercise. One of the most painful features of foot ball is the fact that so many of the injuries received in playing this game, when not immediately fatal, often incapacitate the player for life, and render him a burden on his relatives. Such phrases as the following appear in the English medical periodicals, referring to the Rugby game: "The uncontrollable brutalities and roughness of the pastime."—"Brutal and dangerous." Without doubt the consensus of opinion of surgeons is that no such game as the Rugby should ever be indulged in. Under modified rules accidents happen only too frequently. During two seasons of short duration your reporter observed in the matches he played in, a broken clavicle, a dislocated elbow, a fractured pelvis, a case of temporary unconsciousness, besides many minor injuries, chiefly bruises to the shins and ankles. Even this much happened under rules which did not permit the carrying of the ball. From the medical literature on the subject, it appears that those who would approve of the Rugby game, and who see in it manly qualities, would approve likewise of a bull or cock fight. The chief danger of the Rugby game appears to be affections of the spine, resulting in muscular paralysis.

Cricket.—This pastime is not altogether free from accidents, but I think it may be asserted that if the crease is a good one the accidents will be few. The players who receive most bruises are the wicket-keeper and the batsman. If played, however, according to custom and rules, bruises are very rare. In the past two years while on the cricket field, I noticed a fracture of the zygomatic arch, in a wicket-keeper, and a fracture of the nasal bones in a batsman. Both of these accidents were due, it is altogether likely, to an imperfect crease. No game it appears could be more free from accidents, although it is not uncommon to see a wicket-keeper or a batsman lay sprawling on the ground from the ball occasionally striking the testicle, but the injured one soon recovers and proceeds with the game. Accidents of a more serious nature are very seldom reported from the cricket field.

Lacrosse.—Accidents in this game occur undoubtedly, in proportion to the manliness of the

players, whether they play with the ball or play at each other. It will rest mainly with the umpire if accidents are numerous. It is in their power to prevent them. Many a scalp wound and bruise has occurred unnecessarily; but neither in lacrosse nor in cricket is there any special injury which has taken the name of the sport.

Lawn Tennis.—It is to lawn tennis that we look for special accidents that have taken the name of the game.

1st. We have lawn tennis arm, a rupture of the pronator radii teres, produced by the back stroke.

2nd. Lawn tennis leg, a rupture of the plantaris, the symptoms of which are quite marked and uniform.

3rd. Lawn tennis knee. This last consists in nearly every conceivable sprain or bruise of the ligaments and cartilages of the knee-joint.

I shall not refer to the various motions which produce these injuries, but will simply state that it is well to know that these injuries are inherent in the game of lawn tennis, which has now become so fashionable. An intelligent knowledge of these minor accidents, as it were, are not beneath the careful study of the surgeon. And here I cannot help referring you to an exceedingly clear report of a case of lawn tennis leg, by Dr. Powell, of Ottawa, in the *London Lancet*, of July 7th, 1883.

Bicycle.—As to the bicycle accidents, although their name is legion, there is none which have the name of the game. It is simply alleged that varicose veins of the lower limbs, as well as varicocele, may be caused by it, and that hernia inguinal, if not produced, is at least aggravated by it, but the evidence is as yet conflicting.

Base-Ball.—Accidents from this sport are divided chiefly between the pitcher and catcher. A few years ago I observed, in a pitcher, a swelling and tenderness in the region of the attachment of the biceps to the head of the fibula, no doubt due to a sprain of the muscle. The pitcher's movements are such that it is altogether likely this injury may result from it. On advising him to abstain altogether, he got well, but before doing so the trouble was aggravated at every attempt. He can now, however, ride the bicycle without any return of the affection whatever.

The above is simply an imperfect glance at the accidents in connection with the out-door sports which are so much indulged in.

GUNSHOT WOUNDS.

And here I wish to quote from a lecture delivered by Sir Wm. MacCormac, of St. Thomas' Hospital, London. He states: "That there is infinitely more danger created by the surgeon who attempts to search for and extract a bullet, than would result from leaving half a dozen bullets to take care of themselves." This has not been my own experience in reference to pistol-shot wounds. I shall refer to only one example. A patient came under my observation, who accidentally shot himself in the wrist. He was kept under ether some three hours, it was alleged, but the bullet was not discovered. Considerable inflammation in and about the wrist, with stiffening and a contracted hand following, which only yielded after prolonged treatment. This may have happened without the prolonged search, but with my present knowledge of the subject if the bullet required a search in order to find out its locality, the search should not be made." Further on he states in regard to gunshot wounds of the abdomen: "Some months ago Marion Sims published, in one of the medical journals, an interesting series of papers in which he said that these injuries should not be left to themselves; but what he proposed was that the abdominal cavity should be opened and searched, the bullet be found and extracted, the peritoneal cavity then be cleansed antiseptically and closed, after which treatment it might be possible for recovery to follow, when death was otherwise almost inevitable." Such it appears has been the action taken in reference to gunshot wounds, which has been attended with the best results. But the change is not general yet, and it is to draw attention to this important subject that the above short report of gunshot wounds is made.

MEDICAL NOTES FROM THE NORTH WEST FIELD FORCE.

BY G. STERLING RYERSON, M.D.C.M., L.R.C.S., ED.
Acting Surgeon, Royal Grenadiers.

It speaks well for the constitutional stamina of the regiment to which I belong and also for the field force generally, to be able to report that there is no serious illness among either officers or men. Diarrhoea has been somewhat prevalent, owing largely to the alkaline character of the water, which only was obtainable. There have been a few cases

of dysentery also. Coughs and colds have been common, as might be expected in men unaccustomed to live in tents. Only one case of pneumonia has occurred in this column and that in a man who had suffered from it before. Rheumatism is also met with, but almost invariably of the muscular variety; four men who had suffered previously from chronic articular rheumatism were sent to the rear from the Grenadiers. The sufferings from cold and exposure on the north shore of Lake Superior were most intense, but the men bore up with a most cheerful uncomplaining spirit and no serious trouble arose from it. The most trying part of the journey was the night march on the honey-combed ice, of ten miles to Red Rock, in a blinding rain storm. The men were so exhausted that some went to sleep standing up.

The supply of food has been ample and of good quality, but there has been a great dearth of vegetables, canned or otherwise. Lime juice ought to have been sent to supply their place if unattainable. Common salt is also scarce. Oatmeal would be a boon to the troops. Milk can be occasionally had at 50 cts. per quart and butter at \$1 a pound. The scouts bring in captured cattle which keeps us supplied with fresh meat. The difficulty in obtaining fresh supplies can be imagined when I mention that we are 230 miles from the nearest railway station and in an enemy's country, where the people are forbidden by the rebels to sell us anything on pain of death. We are obliged therefore to help ourselves whenever the opportunity presents itself.

The medical officers with this column are Dr. Orton, P. M. O., Drs. Codd, Grant, Whiteford and myself. I have also eight trained ambulance men under me, with Hospital Sergt. Hazelton belonging to the Grenadiers. They have proved of great use in the recent troubles, and I should urge on all medical officers the formation of such a corps in their regiments; one or two men per company, with one regulation stretcher to every four men is sufficient. The wounded in the battle of Fish Creek were promptly removed to the rear by the bandsmen of the 90th Battalion. They showed great devotion and courage, and were often under fire, as were also the surgeons in going to the front to arrest hemorrhage. I would particularly mention Drs. Whiteford and Grant.

The case of Lieut. Morrow, who was accidentally shot by Mr. Fox, *Mail* correspondent, at Camp

Desolation, is interesting. The ball entered the thigh at its anterior and inner aspect, ran under the skin for about six inches, there the probe stopped. As I could feel no ball I cut down on the end of the probe and found that the probe then took a direction downwards and backwards towards the buttock. I passed the probe in its full length, seven inches, and as I could feel no ball I determined to leave it, especially as he had to travel 60 miles in an open sleigh to get to Dog Lake Hospital. The first direction of the ball was towards the middle of Poupart's ligament, and it is most curious and providential that it should have taken a turn at an obtuse angle and passed into the back of the thigh. A somewhat similar case is that of Pte. Swan, 90th Batt., who was shot at the battle of Fish Creek, April 24th, in the inner side of the left arm at its middle third just over the brachial artery. The ball passed beneath the skin under the edge of the deltoid and disappeared in the axilla. No irritation had occurred a week after the wound had been received. The wounds in this action were nearly all given by large round balls from smooth-bore shot guns. They caused great bruising and crushing of the tissues. Their course was often circuitous. Pte. Kemp, 90th Battalion, was struck just to the outer side of the femoral artery as it enters the thigh. The missile passed between the muscles of the abdomen, followed around the loin and lodged in the muscles of the back. There was cellulitis but no peritonitis. A curious case was that of Lieut. Swinford, who was shot the same day. The ball struck him at the temporo-frontal suture, about two inches above the zygomatic process. The skull was extensively fractured, and there was hernia cerebri, but he was conscious and rational. In this state he continued with occasional nocturnal delirium for five days when his speech became impaired, and he died on the sixth day with symptoms of pressure. At the *post mortem* the ball, a large round one, was found imbedded in the brain at a depth of about two inches. Some portions of bone were found driven in. The skull was extensively fractured on the injured side.

A son of our esteemed confrère Dr. Canniff, was wounded in the same action by a round ball. The projectile entered the posterior surface of the right forearm about three inches from the olecranon process on the radial side and lodged an inch above it. As the arm was in extension at the time it was

wounded, and as no opening could be found into the joint, it is believed that it escaped.

Three amputations were performed, two through the middle of the arm and one at the surgical neck of the humerus, also one excision of the elbow joint shattered by a shot, but vessels intact. All were doing well when they left for the base hospital at Saskatoon, on May 1st. The total casualties were 31 wounded and 10 killed, including 1 officer killed and 3 wounded. The wounded were transported to the rear in stretchers made of hides slung in waggon. They were all comfortable on starting.

Camp, Fish Creek, N. W. T., May 2nd, 1885.

Reports of Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

May 5th, 1885.

Dr. Stark, Vice-President, in the chair.

Dr. Mullin exhibited a pathological specimen—an ovum of two months.

Dr. Leslie then read a paper on "The Germ Theory." The paper went very extensively into the subject from a theoretical point of view, dealing with the researches of different observers as to the nature of cells, and from these proceeding to a description of the various kinds of germs. The subject of spontaneous generation was then taken up and the question of disease germs was considered. After a lengthy description of Lister's views and system, and the various opinions with regard to it, reference was made to Koch's investigations as to the nature of cholera and the discussions that had arisen. Drs. Mullin and Malloch both supported the germ theory, the latter especially speaking with reference to Listerism, which he considered to be increasing in favour and had exerted a beneficial influence. Dr. Rosebrugh gave the particulars of an interview had in Edinburgh with Keith as to the sufferings of the latter when using the carbolic acid spray, and the necessity arising for its discontinuance. Dr. Rosebrugh also spoke of his observations in London and Birmingham, all of which tended to show how much operations now depend on cleanliness. Dr. Leslie, in responding, stated that though at present he thought the evidence was against the germ theory, yet the growth and multiplication of germs in the body was a strong argument in its favour.

May 12th.

The President, Dr. White, in the chair.

Dr. Malloch presented a pathological specimen—carcinoma of the pyloric end of the stomach. Dr. McCargow showed a finger which had been opened for whitlow, but too late, as there was denudation of the cartilage of the articular ends of the first phalanx and the adjoining metacarpal bone of the left fore-finger, while there had been a large abscess formed under the pectoral muscles of the same side extending from the axilla, its original site, to within an inch or two of the sternum, and extending downwards over a space corresponding to three or four ribs.

Dr. Rosebrugh then read a short paper on "Intra-uterine Medication." The paper began by referring to the fact that in the greater number of cases of apparent disease of the inner surface of the organ there is, as a rule, some special cause for the symptoms, such as a flexion or version, which removed, the symptoms will soon disappear under very mild treatment. Consequently in all uterine diseases great pains should be taken to make a correct diagnosis, for experience shows that when the case is thoroughly understood the treatment is simplified and more easily accomplished. As an instance, was given the alarming symptoms presented by a case of chronic retroflexion with laceration of the cervix, so easily relieved if these primary conditions are only remedied. The class of cases requiring intra-uterine medication were summarized as follows: 1st, chronic endometritis with the following characteristics: general enlargement of the body of the organ; considerable dilatation of the corporeal cavity, and the endometrium in a condition of fungoid or cystic degeneration, giving rise to a muco-purulent leucorrhœa and frequently to a profuse menorrhagia. 2nd, uterine catarrh, with an albuminous secretion that persists, despite ordinary treatment. 3rd, habitual abortion, independent of syphilis and ovaritis, and seemingly due to some morbid condition of the endometrium. 4th, membranous dysmenorrhœa. 5th, the flabby uterus frequently associated with subinvolution. Having spoken of the difficulty of separating the treatment of the endometrium from that of the os and cervix, while often if the disease of the latter is removed there is no further trouble with the former, the essayist stated that he no longer used tents to dilate the cervical canal, as he found that the applicator

or curette could be introduced without any previous dilatation. If any was needed, the steel dilator could easily effect it. He stated that he had never used strong caustics in the solid form, though where the endometrium is decidedly diseased it becomes more tolerant of heroic treatment; but in such cases he found the most effective agent to be the fuming nitric acid. This he applies by means of the cotton-wrapped applicator, guarded by a glass tube through the cervix, the lining membrane being pretty well swabbed. Except in obstinate cases, and then only at long intervals, the application has not to be repeated. Never had he seen colic or the other alarming symptoms frequently generated by crayons of strong, solid caustics. Churchill's tincture of iodine has been proven one of the most efficient applications, its action being that of a local stimulant to uterine contraction and a general alterative or nutritive. Nitrate of silver he seldom employs, because of its severity as an astringent to the small blood vessels, and its continued use causing too much contraction of the os and cervix. Its use should be confined to the soft flabby uterus with enlarged patulous os and profuse cervical discharge, its contracting effects being carefully watched. Carbolic acid and glycerine, one part to three, is a favorite mild application, the acid coagulating the albuminous secretion while the glycerine depletes the congested condition of the parts by causing a profuse watery discharge. Persulphate of iron is also a favorite with him when wishing to produce an astringent effect upon a granulating surface. Tannic acid is also a useful mild astringent, but has, like iron, the disadvantage of discoloring the patient's underclothing. Paquelin's cautery and the actual cautery he had no personal experience of, having always effected his purpose by other methods. Intra-uterine injections he considered of service sometimes, but on account of the pain and violent symptoms sometimes following, thought milder methods should be adopted. In old chronic cases, with the uterus decidedly enlarged and diseased, and the os flabby and patulous, the organ is so tolerant of manipulation that even injections may be employed with comparative safety. Whenever fluids are to be injected the cervical canal must be straightened and enlarged so as to admit Chamber's reflex current catheter, or some such device, which will secure a free return of the fluid. A safe method is the use of a small

graduated hard rubber uterine syringe having a long slender nozzle. The syringe having been filled with the fluid to be used, the nozzle is loosely wrapped with absorbent cotton and introduced within the cavity, and then injecting carefully and slowly just sufficient to saturate the cotton, the syringe is slowly rotated so as to swab the whole inner surface. But as injections offer no marked advantage the essayist thinks they should be abandoned, or certainly very rarely employed. In some cases caustics and astringents effect only partial cure. In obstinate endometritis with fungoid degeneration a muco-purulent discharge and long continued menorrhagia, energetic measures are necessary. The denudation of the endometrium must be penetrating. The most effectual method is by thorough curetting. The uterus should be firmly held by tenaculum or vulsellum forceps and the rough portions scraped out without any previous dilatation of the cervical canal. During the curetting, one hand should be placed over the uterus externally, pressing it down so that every part of the inner surface can be reached. The cervix becomes more tractable so that subsequently a larger curette may be employed if necessary. After the denudation the inner surface is to be thoroughly swabbed with fuming nitric acid, Churchill's tincture of iodine, Monsel's solution of iron, or some other agent of a penetrating character. Local treatment must be supplemented by constitutional. Aim at reducing the enlarged uterus by ergot and strychnine, followed by tonics, quinine and iron. In old chronic cases the curetting may have to be repeated two or three times after the menstrual periods, for, do what we will, relapses will occur, so that the treatment must be persevered in. In treating these disorders the constitutional element must be considered, for in some cases both local and constitutional causes are met with, and in most cases constitutional treatment is of great service, but we must aim to remove the cause, whether local or constitutional. Dr. Rosebrugh said that the frequency of the application depended upon the agent employed—as a rule every fourth or fifth day; if the patient came from a distance, once a week. He nearly always employs the cotton-wrapped applicator, and in order to thoroughly cauterize the surface makes two or three applications at each visit. In many cases where the endometrium seems involved he restricts the application at first to the

cervix, and this with constitutional treatment proves sufficient to induce uterine contractions, and the improvement is continuous until a complete cure is effected. When the inner surface is roomy, and the os very patulous, admitting applicator readily, he pushes the applicator into the cavity and swabs the inner surface and then swabs dry with absorbent cotton the cervical portions of the uterus and vagina. A tampon of absorbent cotton, moistened with glycerine and having a withdrawing string attached, is left in the vagina a few hours. In the discussion which followed, the members differed on the following points:

Dr. Malloch thought more attention should be paid to malpositions of the uterus, and that when these were remedied only mild topical applications were necessary, such as hot water.

Dr. Mullin thought the uterus should be regarded as amenable to medical influences as other internal organs to which topical treatment could not be applied. Local treatment might be useful in certain conditions, but in his experience the conditions which give rise to menorrhagia were not always to be benefited by local treatment, on account of the pain suffered from intra-uterine applications, and after these applications had been abandoned he had found some patients much benefited and restored to health by rest, especially during and after the menstrual period, and the use of general remedies.

Dr. Stark said that while he agreed with Dr. Rosebrugh in his treatment, he preferred to treat the patients at their own houses so as to have the benefit of rest at once. He expressed himself as being at first astonished at Dr. Rosebrugh's heroic use of the curette. Since then he had had great success with it.

Dr. Ryall referred to the fact that formerly the great object in treatment seemed to be the dilatation of the cervical canal, while now gynecologists sought by means of trachelorrhaphy to close up the canal, and in conclusion he said he wondered what became of women fifty years ago, before the days of dilatation and contraction and other special treatment.

ST. LAWRENCE AND EASTERN MEDICAL ASSOCIATION.

A meeting of the members of the St. Lawrence and Eastern Territorial Division was held in Cornwall, January 27th, 1885. Present:—Drs. Bergin (chairman), McMillan, Brouse, Moore, Easton, Pickup, Pringle, Alguire, Munro, Harrison, Hamilton, Gravely, S. A. Hickey, G. C. Wagner, Davis, Reddick and Lefevre.

The chairman addressed the meeting upon the

following subjects: the proposed increase of the annual fee to the Council, the advisability of raising the standard of medical education particularly in preparatory examinations, the Imperial Medical Act, the establishment of a code of ethics, and revision of the tariff.

The following resolutions were carried:—That in the opinion of this meeting it is not advisable that the annual fees should be increased to \$5, as proposed by the Medical Council.

That this meeting disapproves of Universities and Colleges having no medical schools in connection with them, being represented in the Medical Council.

That this meeting approves of raising the standard of the matriculation examination. That candidates for matriculation should be obliged to present credentials of matriculation in arts from any Dominion University, which will entitle them to matriculate in medicine upon payment of fees.

That this meeting sincerely hopes and requests that the Medical Council will take such steps as shall forthwith give to this province a legal code of medical ethics.

That this meeting feels very strongly the injustice of being obliged to register Imperial graduates without examination, a privilege we deny our own graduates, and that we desire the Council to take such steps as may be advisable to obtain justice in this matter.

That it is desirable to have a taxing master appointed for each Territorial Division.

That the registered medical practitioners resident in the St. L. & E. Division do now form themselves into an Association, to be known as "The Medical Association of the St. L. & E. Division, the officers to consist of a president, two vice-presidents, a secretary and a treasurer; the president to be the representative of the Division in the Ontario Medical Council, and the other officers to be elected annually. The following were elected:—Dr. Bergin, President; Drs. Brouse and McMillan, Vice-presidents; Dr. Lefevre, Secretary; Dr. Moore, Treasurer.

A committee was appointed to revise the tariff, and their report being adopted, the Secretary was instructed to forward it to the Territorial representative, to be submitted by him to the Medical Council for approval at the June meeting.

J. M. LEFEVRE, M.D., Sec.

Selected Articles.

REVIEW OF THE GROWTH OF McDOWELL'S OPERATION IN 1809.*

BY R. S. SUTTON, M.D., LL.D., PITTSBURG.

In the bleak cold of a December day, in 1890, a woman riding on horseback, arrived in Danville, Kentucky. She had taken farewell, perhaps forever, of relatives and friends, and had just completed a journey of sixty miles that she might be near a surgeon, who had promised to open her abdomen, and endeavor to remove a large ovarian cyst it contained. She was to be the subject of an experiment—an experiment at the hands of a surgeon living on the borders of civilization—an experiment which would involve her life, and to which she must submit without the blessing of chloroform or ether. This woman possessed of marvellous courage was Mrs. Crawford, McDowell's first patient in ovariectomy, and the first patient on whom the operation was ever deliberately undertaken. She recovered and lived to the advanced age of seventy-nine years, a period of thirty years beyond the operation.

The conditions surrounding, and forming part of this operation, are worthy of more than a passing notice. At the present time, they are declared by the ablest operators to be of more than accidental importance.

In the light of all the recent advances concerning the environs of an ovariectomy patient, I ask you to listen thoughtfully, and inquire of yourselves: Have modern operators had better environments than McDowell? Is their quarantine better than his was? Whether accident, or necessity, or the simplicity of border life, provided these conditions so favorable to recovery, your orator will not inquire, but hopes to show that McDowell did operate under conditions as favorable as does Dr. Keith or Mr. Lawson Tait.

1st. The patient was refused operation in her own home.

2nd. She was operated upon in Dr. McDowell's own house.

3rd. History mentions but one assistant present at the operation.

4th. The patient had never been tapped.

5th. We may safely infer that the room in which the operation was performed, contained, at this early date in Kentucky, no superabundance of furniture or upholstery.

6th. That the room was ventilated by an open fire-place is more than probable.

7th. The atmosphere was that of a healthy border town.

8th. No sponges were introduced into the abdomen.

9th. He ligated the pedicle and dropped it in.

This operation will stand the criticism of the most exacting specialist of the year 1885, save in two particulars: viz., the ligature was not carbolicized or scalded, the ends of it were left hanging out of the lower angle of the wound, and merely turning the woman on her side to permit all fluids to escape from the cavity of the abdomen was scarcely enough in that direction.

The incision was made on the left of the rectus muscle, but in his next case McDowell made it in the linea alba, between the umbilicus and pubis.

Pause a moment! Think; at the end of almost three-quarters of a century, the operation stands almost where McDowell left it, with one solitary exception, viz., the ends of the ligature surrounding the pedicle are cut short.

Restless human nature, not satisfied sought other means of treating the pedicle, a review of which is fraught with good instruction. For eleven years the operation remained in the hands of McDowell, and he adhered to ligation of the pedicle, leaving the ends of his ligature hanging out at the lower angle of the wound. In 1820, Chrismar, of Württemberg, tied the pedicle in two portions, leaving the ends of the ligature hanging out at the lower angle of the wound. In 1821 Nathan Smith, of New England, tied the pedicle with "strips cut from a kid glove;" he cut the ligature off close to the knots, and dropped the pedicle into the abdominal cavity.

Neither Chrismar nor Nathan Smith knew anything of McDowell's operations. Were the teachings of Hunter and John Bell working upon other minds, as well as upon the mind of Dr. McDowell? The last named sent to Mr. John Bell, of Edinburgh, an account of his cases. Mr. Bell being then in Italy, his colleague, Mr. Lizars, received the report. It is probable that this record was received in 1818. For six years Mr. Lizars kept it to himself. He attempted ovariectomy four times, and succeeded in one case, the patient surviving the operation seventy days. In one case he opened the abdomen by an incision reaching almost from the ensiform to the pubis, and thrust his hand into an empty belly. He requested every one of his students to put his hand into the abdomen, and finally exclaimed, referring to an army officer present, "Where is the military gentleman?" and had him make the same manual exploration. Mr. Lizars then closed the wound, *and it healed by first intention.*

Owing to the fact that Mr. Lizars's results were bad, twenty years elapsed before ovariectomy was again attempted in Scotland. In 1845, Dr. Handyside performed it. Another halt of seventeen years occurred, bringing us up to 1862, at which date but one success had been attained in Scotland.

* The Address in Obstetrics, Am. Med. Association.

In that year Dr. Thomas Keith did his first operation.

Let us now cease the pursuit of Dr. McDowell's operation, as it was reported to Mr. John Bell, which report the latter did not live to see.

Up to the year 1843, I find the records of only eighteen completed ovariectomies in America. In this year Dr. Alexander Dunlap, of Springfield, Ohio, and Dr. John L. Atlee, of Lancaster, Pa., did their first cases, the latter removing both ovaries. Eleven years later (1855), Dr. Kimball, of Lowell, began operating. These three are now the only living pioneers of the army. May they live long to enjoy the distinction!

The operations in the United States were already numerous, and the stability of the operation secured. This was before Sir Spencer Wells did his first ovariectomy.

It is estimated by Peaslee that up to the last quarter of 1863, over three hundred ovariectomies had been done in this country. At this date, Dr. Keith was only beginning in Scotland; the operation was performed for the first time in Russia, and was only a year old in Italy. Twelve years after the death of Dr. McDowell, in 1842, Dr. Charles Clay, of Birmingham, England, did the first operation in that country; prior to this time, Jeaffreson, Walne, King, and West had each removed by abdominal section, parovarian cysts. In 1851, Baker Brown began operating in St. Mary's Hospital, London; his results were not good, and the intense opposition of his colleagues drove him from the hospital; he then founded "The London Surgical Home," where his results compared favorably with those of any other surgeon of his time. *It was mainly due to his action that the practice of performing ovariectomies in large hospitals, where isolation is impossible, ceased.*

From Baker Brown, Nélaton learned the operation by personal observation, and returning to France, related, in a public lecture, how he had seen Brown do five cases, three of them in a single day; and thus through the influence of Brown on Nélaton, the opposition to ovariectomy in France was largely diminished. In 1854, Baker Brown taught Sir Spencer Wells the operation, and in 1857 Sir Spencer did his first operation. In 1864, according to Sir Spencer Wells, the operation was completely established in London, and, we may add with pride, in every country in the civilized world.

But while the surgical world recognized the operation, there was a diversity of opinion with regard to the treatment of the pedicle. From the date of Dr. McDowell's first operation up to 1821, when Dr. Nathan Smith operated, the ends of the ligature were brought out at the lower angle of the wound; Dr. Smith was the first to cut the ends off. For sixteen years after, no other method was offered. In 1837, Stilling of Cassel, in the province of

Hesse-Nassau, Germany, used the cautery, and suggested stitching the pedicle to the wound.

Nine years barren of new suggestions again elapsed, when, in 1846, Dr. Handyside, of Edinburgh, Scotland, carried the ligatures through the cul-de-sac of Douglas into the vagina. In 1848, Stilling treated the pedicle outside of the peritoneal cavity. Two years later, in 1850, this method was inaugurated in London by Mr. E. W. Duffin. The introduction of the extraperitoneal method of treating the pedicle by Stilling, in 1848, began a long and serious conflict which has happily died out with the method. Maisonneuve, of Paris, in 1849, had twisted the entire pedicle in one case, and Martin of Jena, had stitched the pedicle to the wound. About this time Langenbeck stitched the pedicle to the wound, and covered it with the skin from the margin of the incision.

Eight years later, in 1850, Dr. John L. Atlee, of Lancaster Pa., introduced the *écraseur* to divide the pedicle. He was imitated by a number of prominent operators, notably by his brother the late Washington L. Atlee, Sir Spencer Wells, Dr. Keith, Professor Pope, of St. Louis, U. S., and Professor Billroth, of Vienna. This year proved unfortunate for the operation, for during it Mr. Jonathan Hutchinson invented the clamp which perpetuated the extraperitoneal mode of treating the pedicle. In 1860, Sir James Y. Simpson secured the pedicle within the cavity of the abdomen by acupressure needles passed through the abdominal wall. About 1865, Koeberle, of Strasburg, invented his *serre-nœud*, or wire constrictor, with which he grooved the pedicle prior to applying the ligature.

In 1864, Mr. I. Baker Brown, of London, reverting to Stilling, of Cassel, established the use of the cautery, a method rejected in London, taken up by Dr. Keith, and now credited through him with the best statistics yet attained by any operator. In 1868, Masslovsky, a Russian, amputated the pedicle by double flaps, one on each side, and stitched the flaps together. In 1869, Dr. McLeod, of Glasgow, Scotland, by means of two pairs of strong forceps, twisted the pedicle entirely off. During this year, Dr. Peaslee invented a scabbard and knife by means of which the pedicle was secured, the ligature traversing the scabbard. After forty-eight hours the ligature was cut by introducing the knife into the scabbard, when both ligature and scabbard were withdrawn. In 1870, Dr. Thomas Addis Emmett reported eighteen cases in which he had secured the pedicle by means of silver wire.

Up to the present year (1885), every conceivable thing has been done with the pedicle. It has been tied entire; tied in sections; been twisted off; burnt off; crushed off; cut square off; cut off in flaps; left inside; left outside, and then made to slough off. The extraperitoneal method of treating the pedicle is gone. The question is now resolved into the merits of the ligature

cut short, the Dr. Nathan Smith method, or the clamp cautery, as introduced by Mr. I. Baker Brown, of London, in 1864. If the clamp as devised by Mr. Jonathan Hutchinson was a bad instrument, and according to Mr. Tait, reduced the statistics that Sir Spencer Wells should have attained, it must have similarly affected the results of those who have employed it in the United States. Recently ligation and the cautery have given almost equal results.

The operation of Dr. McDowell in so far as it relates to the treatment of the pedicle, is, therefore, triumphantly where he placed it, despite the ingenuity of the surgical world, having undergone but a single alteration, namely, Dr. Nathan Smith's improvement of cutting the ligature short. I have not been able to learn anything as to the extent sponges were used by the pioneer operators. When Dr. Keith was about to do his first operation, he had the water to be used boiled the night before, and he made everything scrupulously clean; during the operation he was surrounded by old practitioners.

After removal of the cyst, he thrust a big sponge into the abdomen, and brought it out full of fluid. As he was about to repeat this, one of the doctors seized his arm, and exclaimed, "For God's sake don't do that again." While he hesitated, the others argued that any fluid left in the body would be a nice protection to the intestines. He closed the wound. Subsequently the patient did badly. He at once opened the wound and let out a pint of dirty fluid, and the patient recovered. From that time he advocated careful sponging after the operation, *and he was the first to insert a flat sponge under the wound while the stitches were being placed.* Koeberle, who also began to operate in 1862, introduced the compression forceps and drainage, first by short and later by long glass tubes.

I here show you the Baker Brown cautery clamp, used by Dr. Keith, the compression forceps of Koeberle, also the modification of Sir Spencer Wells, and the drainage tubes so much in use by operators in great Britain.

The technique of McDowell's operation is, probably complete, *and its future will depend on the subject, the place of application, and the care taken to protect the patient from extraneous sources of danger.* It may be compared to a mighty oak, each decade of years having added to its greatness until its far-reaching branches furnish shelter for the thousands of men and women who require abdominal section. Its ramifications are hysterectomy for fibroids, hepatotomy, cholecystotomy, normal ovariectomy, the Hegar-Tait operation for the removal of both ovaries and tubes, nephrectomy, exploratory incisions, gastrotomy, and enterotomy. It still continues to grow, and the task of pointing out the leaves that have been added to its foliage during the last year requires our efforts ere they

fall about the roots and contribute themselves to the growth of the parent tree.

Valuable lectures and papers have been given by Dr. Keith, M. Lawson Tait, Mr. Savage, Sir Spencer Wells, and Mr. Bryant, all in the *British Medical Journal*.

The results of valuable experiments on lower animals have been published by Prof. C. T. Parkes, of Chicago. Many successful cases of the Hegar-Tait operation done by our countrymen, and the surgeons of Great Britain, have been published in various journals.

Mr. Thornton has been successful in gastrotomy for the removal of a large foreign body, and has had seventeen successful cases of nephritic surgery ten of these being nephrectomy by abdominal section. Drs. Keith and Bantock continue to do supravaginal hysterectomy with unparalleled success, and it is premised that if their success continues, it will elevate their method of operating beyond the reach of controversy. They both adhere to the extraperitoneal treatment of the stump, while the continentals practise the intraperitoneal method.

The recent visit of Mr. Lawson Tait to the United States, has given great impetus to the Hegar-Tait operation for the removal of diseased tubes, and for the removal of ovaries and tubes for the cure of fibroids of the uterus.

For the purpose of encouraging the conservative abdominal surgeons, *those who look carefully to the environment of their patients*, I point with great pleasure to the fine statistics of Dr. John Homans, of Boston, and of Dr. Robert Battey of Georgia, whose early initiation of normal ovariectomy was suggestive eventually of the Hegar-Tait operation which included the tubes.

Ovariectomy and its offshoots comprise almost, if not the entire field of abdominal surgery. The establishment of the parent operation brought out the others, if not for the first time, it revived and established them after they had been practically abandoned. "The seed sown by Bell and Hunter, carried by McDowell, and planted in Kentucky," its first growth was slow, but gathering strength from the passing years, its top has risen high, and its great branches cover a wide space, where unfortunate men and women of every land and clime gather to find relief from suffering and to acquire new leases of life.

The carbolic spray is still a matter of dispute. In Great Britain, Mr. Thornton adheres to it as of old, Drs. Keith and Bantock, and Mr. Tait will have none of it. The latter said to me, "I sold out all my right, title, and interest in Listerism, with my tea-kettle to Battey."

So far as I know the best statistics yet obtained in ovariectomy in the United States belong to Dr. Battey, of Georgia, and Dr. John Homans, of Boston, Mass., both of whom operate under the carbolic spray,

and in apartments kept especially for abdominal operations. I make special mention of the fact that these gentlemen use the carbolic spray, for the reason that Dr. Emmett says, in his last edition, p. 715, "I do not know of any prominent operator in this country who now uses the spray," evidently an oversight.

I do not use the spray myself, but look upon the entire Lister system, less the spray, as firmly grounded in the surgical mind. Cleanliness and Listerism can never be separated, for "Listerism is the gospel of cleanliness;" without the latter you cannot have the former.

The year has wrapped up in its eternal folds one whose name is synonymous with the surgery of women; whose reputation is immortal, who in America at least, stood next to McDowell; beloved by his own countrymen honored by the entire surgical world. No eulogy of mine can increase his fame. I speak of *the great, the good, the pure, the noble, the generous* Marion-Sims. Like McDowell, he possessed a genius for origination, and will share with him the admiration and plaudits of future generations.—*Med. News.*

HYPERTROPHY OF THE PROSTATE.

The gradual invasion of symptoms of urinary obstruction in a man of advancing age would always suggest the probability of hypertrophy of the prostate. But the existence of this condition may be demonstrated by a digital examination. The patient is placed in a supine position; the surgeon stands on his left side, and introduces at least two phalanges of his left index finger, slowly and gently into the rectum, while the patient's knees are flexed and separated from each other. The surgeon examines whether the enlargement involves one or both lateral lobes, equally or unequally, whether it affects chiefly the breadth or depth, whether it is soft or hard, regular or irregular, solid or fluid; whether fluctuation can be felt in the bladder behind the prostate. He should also examine as to tenderness on pressure, its degree and locality: he should also estimate the temperature of the parts. Prostatic calculi can sometimes be detected by the finger. While making these examinations with his left hand, he should introduce a catheter with his right hand, while the left index finger judges as to the thickness of the intervening tissues. The catheter should be of as large size as the calibre of the urethra will allow. If urine flows freely when the catheter has not penetrated more than $6\frac{1}{2}$ to $7\frac{1}{2}$ inches, and the handle is not much depressed, it is fair to infer that there is not much enlargement of the prostate. If the catheter has passed 8 or 9 inches, and the urine does not flow until the handle is considerably depressed, there is good evidence of prostatic enlargement. A pros-

tatic catheter, longer than the ordinary catheter, and its beak nearly at right angles with its shaft, will be required, in such cases, to draw off the urine. Or a long soft catheter may be employed.

To explore the interior of the bladder, an instrument with a short beak, like Leroy's or Mercier's may be used.

Treatment.—There are three principal indications: *First.*—To obviate the results of obstruction. *Second.*—To improve the constitutional condition of the patient. *Third.*—To diminish the enlargement, or to retard its growth.

The first is the chief indication. The bladder should be evacuated as thoroughly as possible at least once in twenty-four hours. It is often desirable to do this three or four times a day. When the residual urine amounts to only two or three ounces, once a day may suffice. When it amounts to five or six ounces, the bladder should be evacuated at least twice in twenty-four hours. When the power of urinating is nearly lost, the catheter should be introduced as often as the desire to void urine is felt. The patient should be taught to introduce the instrument himself. In determining the question as to the use of the catheter, the degree of irritability of the bladder and of the urethra, and the acrimony of the urine are to be taken into account. When the urine is acrid and fetid, the bladder should be washed out with warm water, and with antiseptic lotions. The patient should be taught to use a flexible catheter, when it is practicable. But special care should be taken to avoid the use of flexible catheters which are worn or cracked, or which have their eyes deformed. The eyes of the catheter should be of full size, as the urine is often viscid, and will not flow through a small aperture.

But in some cases, a silver catheter must be used, and great care should be taken in instructing the patient, that he may do himself no injury. In using a flexible instrument a stilet six inches long may be used, stiffening the handle, but leaving the distal end flexible. When there is retention of urine, and the catheter is passed with great difficulty, it may be left in a number of days. The pressure of the instrument may, perhaps, cause some absorption of the hypertrophied part. To guard against the injurious consequences of non-evacuation or imperfect evacuation of the bladder, the use of the catheter is very important.

In cases in which treatment has been neglected and there is a very large amount of residual urine, a pint or more, it is not safe to withdraw more than half of it at once. From day to day, the quantity withdrawn may be increased, and, in the course of a week or two, the bladder may be emptied. The danger of the complete and sudden evacuation of the bladder under these circumstances was first indicated by Sir Benjamin Brodie.

When the disease has not advanced to the de-

gree which has been mentioned, there are certain complications requiring attention :

1st.—*Atony of Muscular Coat of Bladder*.—This is usually relieved in part by the regular use of the catheter. Other means may be of service. Cold applications over the abdomen twice a day. Cold injections into the bladder every day, or every other day. Electricity, strychnia, iron, ergot.

2nd.—*Chronic Cystitis*.—This is indicated by frequent and painful micturition, with pus and mucus in the urine. Relief is often afforded by washing out the bladder with warm water—100° Fahrenheit. The water may be introduced into the bladder by an India-rubber bag with a nozzle adapted to the catheter, or with a fountain syringe. But a more convenient instrument for the purpose is a hard rubber syringe, which has been constructed under my direction by Tiemann & Co., of New York, and which is known as Post's Vesical Syringe. It holds four ounces, and is of such a shape that it can easily be worked with one hand. Its distal extremity is adapted to a moveable tube, provided with a stop-cock, and tapering from a circumference of 30 mm. at the base to 10 mm. at the apex, so that it will fit a catheter of any size in ordinary use. Both ends of the syringe can be unscrewed, so that either end of the piston can be renewed by the surgeon without the aid of an instrument maker.

After the bladder has been washed out with warm water, mild astringent injections may be employed, such as mineral acids largely diluted; weak solutions of acetate of lead, nitrate of silver, etc. Hot hip-baths may often be used with advantage: also, hot fomentations over the abdomen. Counter-irritants are sometimes useful, as sinapisms and blisters. I have seen very great benefit resulting from the use of the actual cautery in the hypogastric region. Leeches may often be applied with great advantage, to the perineum or around the anus.

Internal remedies are often of service, such as diosma crenata, pareira brava, uva ursi, triticum repens, copaiba, cubebs, ol. santal, demulcents. Gross recommends highly infus. uva ursi and hops. Alkalies often have a very soothing influence even when the vesical urine has an alkaline reaction.

3rd.—*Irritability of Bladder*, with frequent painful micturition. Opiate suppositories are often useful. Ext. belladonna or hyoscyamus may sometimes be combined with it. Opiates may also be given by the mouth. Chlorodyne has been given with advantage. When there is phosphatic deposit, inject the bladder with weak nitric acid once in a day or two—one or two minims to $\frac{3}{4}$ j: quantity $\frac{3}{4}$ i j to $\frac{3}{4}$ iv. A solution of acetate of lead, gr. j to iv, to an ounce of water,—when urine is fetid, carbolic acid 1 per cent.

In cases of vesical hæmaturia, gallic or tannic acid may be given internally, gr. v or vj, ter. in

die. Mineral acids. Ol. terebinth, x to xv, in emulsion. Sesquichloride of iron. When hæmorrhage is alarming, a bladder filled with ice may be applied to the hypogastrium or perineum. Ice-water may be injected into the rectum, or ice suppositories may be used. A collection of blood in the bladder will often obstruct the eye of a catheter when the patient is in an erect posture; but when he assumes a supine position, the blood will gravitate towards the posterior part of the bladder, and the urine will flow through the catheter. The attempt to break up the clot is likely to cause fresh hæmorrhage. When there is complete retention from a clot, and symptoms are urgent, Bigelow's or Otis' Evacuator may be employed. In extreme cases cystotomy may be resorted to.

Incontinence of urine may occur; this is usually an overflow from a distended bladder, but there may be inability of the bladder to retain more than a very small quantity of urine. In either case, an India-rubber receptacle may be worn.

There is often liability to congestion and inflammation from slight causes, as exposure to cold, riding on horseback, journeying, sexual excitement, alcoholic stimulants, etc., giving rise to fever, gastric disturbance, muco-purulent or bloody discharge. Relief is afforded by warmth, rest in bed, laxatives and anodynes. In such cases, there should be great gentleness in use of catheter,—leeches around anus, dry cupping in perineum.

General Treatment of Patients with Enlarged Prostate.—Carefully guard against catarrh, indigestion or constipation. Diet carefully regulated—avoid indigestible food. Alcoholic stimulants should be altogether avoided or their use carefully regulated. Warm clothing, dry feet, warm foot-baths and general baths. Muscular exercise should not be neglected, but it should not be carried to such an extent as to produce great fatigue. When the patient is tired, he should rest in a horizontal position; he should avoid despondency, and keep up his spirits by cheerful society, employment and recreation.

Special Treatment of Enlarged Prostate.—Medical treatment has not yielded very satisfactory results. Conium, different preparations of mercury and iodine, muriate of ammonia, and various mineral waters have been recommended, but none of these remedies seem to have exerted any remarkable influence in diminishing the bulk of the prostate, or in retarding the progress of the disease. The use of ergot by the stomach or by hypodermic injection has been recommended. Henry Morris, in a paper published in the *Lancet*, December, 22nd, 1883, states that he has seen great benefit from the use of ergot. Dr. Washington L. Atlee, in an article published in *N. O. Med. and Surg. Journal*, August, 1878, gives similar testimony. Under its use, several of his patients were able to dispense with the use of the catheter. He

gave 20 drops of the fluid extract every four hours, until a decided improvement took place, and then diminished the frequency, finally giving only one dose at night.

In the *Brit. Med. Journal*, 1878, vol. II, page 500. Dr. William Bird, of York, states that he has derived great benefit from the hypodermic injection of ergotine in doses of $\frac{1}{3}$ of a grain.

Pressure has been recommended as a means of diminishing the bulk, or retarding the growth of a hypertrophied prostate, and the use of large catheters or sounds is probably of some service in this respect.

Electricity has been recommended, but it has not realized the expectations of those who have used it.

The removal of obstructing portions of the prostate by ligature, excision or crushing has been recommended, but there is a difference of opinion among surgeons as to the expediency of this method of treatment. Gouley recommends a median incision of the perineum, opening the membranous part of the urethra on a grooved staff, and introducing a catheter into the bladder. In a more severe class of cases, he recommends the ablation of the median prostatic outgrowth. He explores the prostate by introducing a finger through the perineal section, and if a median outgrowth or isolated tumor be discovered, he enucleates the tumor, or excises the outgrowth, or removes it with a wire écraseur. After the removal of the tumor, he leaves a catheter in the bladder a number of days. —*New England Med. Monthly*.

ON DIET IN DISEASE.

Dr. J. Milner Fothergill gives the following in the *Medical Times*, May, 2, 1885:

A patient amused me very much yesterday. She had been for some time getting weaker and thinner, with her liver out of order, while her medical man had been feeding her upon meat and giving her vegetable tonics and iron, but without good result. At last she suspected that the treatment did not suit her, and so consulted me. When asked to put out her tongue, she observed, "The other doctor never asked to look at my tongue." If he had, he might have been more successful with his treatment. "Has he been giving you steel?" I asked. "Yes, and it did not agree with my liver," she promptly added, evincing a shrewdness that took me aback. On vegetable tonics without iron, and much lighter food, she got on famously. Yesterday she called to report her improvement.

Some time ago, in conversation with the manageress of one of the many Homes now springing up where paying patients can be nursed, the subject of feeding sick persons cropped up, and she

was very enthusiastic about "a twenty-minutes pudding," but of what it consisted did not transpire. A tentative remark about the digestion of the starchy materials of our food flew past her unheeded. It was soon clear that of any rational ideas of digestion, theoretically or practically, she was in unilluminated ignorance: all she knew was a little empirical knowledge, and of that she did not possess a superabundance. Who then, is to know this matter of feeding? Who is to tell the student of the difference betwixt raw or uncooked starch and cooked starch?—that in the latter the insoluble starch-granule is not only cracked, but the starch is largely converted into soluble dextrin by exposure to heat? that by the addition of some such soluble carbo-hydrate to meat-broths they endow these broths with a decided food-value? and that the meat-broth itself is but an agreeable vehicle for some food? Yet this is what he ought to be instructed in, if he is to be fitted to meet disease. When the patient sinks of exhaustion, of what does he die? His stores of force are run out; but what is the material which constitutes the body-force? I should read with delight a lecture upon this topic by Dr. Austin Flint or Dr. Da Costa,—or perhaps some less illustrious physician will grapple with the topic. We know that when a patient declines all food he will die in a given number of days. If a healthy person be hungered, as by shipwreck, he also will live a given number of days. In the latter case death will come all the sooner if the surrounding temperature be low. In the former case the duration of life will be shorter as the body-temperature rises. There is a question of combustion involved. It may not be the whole question, but it is an important factor! Alcohol is a readily-combustible hydro-carbon: it is used freely in critical times. Does not the idea naturally suggest itself that somehow the store of glycogen—the body fuel—is a cardinal matter? If this be so, it is evidently desirable to keep up the stock of this material so that it may not be exhausted. If raw or uncooked starch be employed, probably it is little acted upon by the diastase of the saliva, or even the diastase of the pancreas, both organs being crippled by the general malaise. But a starch which has been rendered soluble by previous baking or by the matting process has been so modified that it is highly soluble.

I do not know how the matter stands in the United States, but as regards the mother-country, little, very little use indeed is made of those prepared foods spoken of—sometimes derisively—as "Baby-Foods," either in cases of primary dyspepsia or in that debility of the digestive organs which is involved in serious morbid conditions. Yet by the addition of cooked starch, as biscuit-powder, to meat-broth, and of malt preparations to milk or milk somewhat diluted with water, foods

nutritive and at the same time readily assimilable are furnished to the sick person. Of the advantage of a fairly competent knowledge of such foods, both in their chemical elements on the one hand and in their variety on the other, probably no one can be better aware than myself: and such knowledge has been of infinite service to me, or some grave delusion exists in my mind. We must, too, remember another aspect of the subject,—viz., variety. While we are in health we are apt to growl about lack of variety in our food: how much more, then, the sick man! If the changes can be rung by different forms of meat-broths combined variously with different prepared foods, how much variety can be furnished to sick persons, and with that how much inducement to take that nourishment, so badly wanted and so hard to supply in many instances! Sago, tapioca, and rice or barley can all be placed in a slow oven and baked for an hour without scorching, and so be prepared for use in the sick-room. When the patient is convalescing, a milk pudding can be prepared of such material, which requires but little of the digestive act. Or there are various forms of plain biscuits which are admirably adapted for use with broths or soups (the Channel Islanders always thicken their soups with biscuit broken fine or powdered). By such means a good and, indeed, substantial meal can be furnished to a phthisical person with softening tubercle and a feverish temperature,—a typical instance of enfeebled digestion due to general malaise. And as for gastric catarrh or atonic dyspepsia, such a meal would not be likely either to become enfolded in a layer of mucous or to present any difficulty as to solubility. These may seem very simple matters, scarcely worth putting on paper; but the professional acquaintance with them is not as ample as it might be with advantage to invalids and sick persons. When a medical man lifts his eyebrows or protrudes his lip when "Baby-Foods" are mentioned in relation to dyspeptics and persons acutely sick, the impression he makes on my mind is this: that he has not made a study of the matter of food and its digestion, and that he has yet to learn some matters which, when acquired, will enlarge his usefulness and strengthen his hands when he stands by the bedside of his patient.

DURATION OF CONTAGIOUSNESS IN INFECTIOUS DISEASES.

The only attempt within my knowledge to formulate experience in respect of the duration of infectiousness, is that of Dr. Miller, of Dundee, whose tabulation is as follows:

Small-pox—14 days after termination of scabbing.
Typhus—28 days from inception.
Scarlet fever—7 weeks from inception.

Diphtheria—6 weeks from inception.

Whooping-cough—8 weeks from inception.

Measles—6 weeks from inception.

Small-pox.—As to small-pox, there is practically unanimity in regarding the danger as existing until all crusts are removed; but a few incline to prolong even further the period of isolation.

Typhus Fever.—In relation to typhus, there is less accord. One deems fomites the most important factor in the dissemination of the malady, while the rest lay stress on personal contagion. One regards it as "not contagious after a short interval;" a second advises segregation until repeated baths have followed the complete disappearance of the cutaneous exanthem; a third, somewhat indefinitely, would permit return to school "after complete recovery and disinfection."

Typhoid Fever.—Those who believe in the direct personal contagiousness of enteric fever are few in number, and I fancy that nearly all of us will agree that the intestinal discharges are all with which preventive medicine has concern. Whether these retain their infectious properties during the whole process of the malady is a question still in uncertainty, and rendered more obscure by the apparent demonstration that the disorder may, under certain undetermined circumstances, be generated *de novo* from ordinary sources of filth-poisoning. At all events, isolation of the person seems unnecessary as soon as convalescence is complete.

The same considerations will apply, I believe, to cholera, with the further remark that, if Koch's recent observations are correct, the germs of this disease appear to be shorter-lived than any other known species, being destroyed not only by desiccation, but by the "scavenger-bacteria," which conquer them in the struggle for existence in the products of common decomposition.

Diphtheria.—Diphtheria affords a wider debatable ground. To begin with, there are many (among whom my own experience forces me to class myself) who assign the first place in the pathogeny of diphtheria to the filth-poisoning, and doubt its exceeding contagiousness. Of a number of persons exposed to the same pathogenic conditions, it is not surprising that several should succumb; but this is not convincing evidence of transmission from one to the other, and I have seen repeated instances where, despite intimate contact, the disease failed to extend after its introduction into places in proper sanitary condition. One of my correspondents, who has long had charge of a large hospital for children, believes this malady to be feebly, if at all, contagious, and finds it quite safe to remit quarantine "after the disappearance of membranes;" a practical sanitarian, of national reputation, excluding fomites and filth in air or water, does not believe in personal contagion; a distinguished teacher in one of our metropolitan colleges doubts "its communica-

bility, except by contact ;" another, equally eminent, declares that contagiousness endures until the last trace of inflammation or infiltration secondary to the diphtheritic process has disappeared ; a fourth would protract the duration of quarantine for a month, or at least three weeks, after all symptoms had abated, and would forbid return to school while any redness of the fauces or any coryza lingers. The discrepancy of opinions in this respect among the leaders of professional thought suffices to show the need of more definite data to guide our deliberations.

Whooping-cough.—In pertussis, all opinions agree, save one, that contagiousness ends when the cough loses its spasmodic character, the single doubtful view being that, as the danger is wholly from the breath of the patient, it cannot be determined how long the cough may convey infection. It should be remembered, however, that a few writers have expressed doubts of the contagiousness of pertussis in any stage.

Measles.—With regard to measles, I find equal diversity of views. One regards its contagium as very volatile, not long adhering to person or clothing, and permits the return of the patient to school in two weeks after convalescence ; a second would defer liberation from quarantine until a week, at least, after desquamation ; a third releases the patient when desquamation has ceased, or in cases where no desquamation occurs, after twenty-one days ; a fourth fixes eighteen days ; a fifth believes the danger past when the febrile stage and eruption are gone. The majority measure the time of isolation by the process of epidermal exfoliation.

Scarlatina.—In scarlatina, also, we have opposing opinions, ranging from that which considers it a pythogenic disease, slightly, if at all, contagious from the person, to that which holds the infection to be communicable by the pulmonary exhalations, the blood, the naso-pharyngeal secretions, even the urine, as well as by the epithelial scales. One of my correspondents thinks the infection remains so long attached to the person, that quarantine should endure for eight weeks ; another cites an example of transmission after six weeks of isolation followed by a change of clothing ; the rest concur in releasing the patient after desquamation has ceased and the surface been thoroughly cleansed. Most of us ; I dare say, have adopted this "rule of thumb."—*N. Y. Med. Journal.*

ACTINOMYCOSIS.

Some incidental remarks made at a recent meeting of the Pathological Society revealed the existence of the first genuine instance of Actinomycosis in this country. The case occurred, we believe, in the practice of Dr. Harley at St. Thomas's Hospital, the post-mortem examination being made by Dr.

Sharkey, and the microscopical examination by Mr. S. G. Shattock, curator of the museum. As the disease in man has only been recognized within the past decade, and as no cases have hitherto been recorded in this country, it is not surprising that but few members of the profession in England should be acquainted with it. A valuable clinical contribution to our knowledge of the affection in man, has recently appeared from the pen of Dr. J. Israel.* In 1882, professor Ponfick published an almost exhaustive monograph on the disease, in which most of the facts then known were embodied. From questions which have been addressed to us, we believe that a brief account of the elemental features of the affection will be welcomed by the majority of the profession, to whom the malady is unknown.

The affection is presumably one which is dependent on the presence and activity of a micro-organism. The micro-parasite is a member of the fungoid class, and consists chiefly of a mycelium which divides in a dichotomous fashion, and gives rise by its spread from a centre to a radiate appearance, whence its name—actinomyces—is derived. The circumferential ends of the mycelial sprouts have a flask-shaped swelling. The little masses of felted mycelium may be recognized by the naked eye as sulphur-yellow bodies of about the size of a hemp-seed. The disease which this parasite is supposed to cause may develop in many parts of the body. The most common site appears to be the jaw and parts bounding the mouth. The affection in animals has long been known in this situation under various names, and has been regarded as a form of scrofula and as a new growth. It is believed that the parasite gains an entrance through the medium of a carious tooth, or some wound of the gum leading to the jaw bone. There is but little to be said of the morbid anatomy of the disease. A swelling forms in the jaw, and gradually increases in size. This tumor in its earliest stages may be punctured without any matter being let out, although it generally has an elastic and semi-fluctuating consistence. A section made into a tumor in the early stage of its existence shows a reddish-white area sprinkled in places with gold-coloured granules. Later on abscesses and fistulæ form, in the discharge from which sulphur-colored bodies may be seen. Broadly speaking, the tissue of the morbid new growth, which must be regarded as inflammatory rather than sarcomatous, has very much the characters of ordinary granulation tissue. Actinomycosis may occur primarily in the respiratory tract proper, and Dr. Israel makes this class of cases his second group. He narrates a case in which the disease was localized to the bronchial mucous membrane. The patient was a girl aged fifteen, who suffered from the signs and symptoms of chronic bronchitis,

* Klinische Beiträge zur Kenntniss der Actinomycose des Menschen. Berlin : A. Hirschwald.

with fetid expectoration, in which the actinomyces were readily discovered. Another case of a man, aged twenty, is given, in which the primary localization of the disease was in the parenchyma of the lung; it was afterwards propagated to the pleura and to the prævertebral tissues. Some of the cases have many of the clinical characters of empyema with discharging sinuses, and in such cases a complex system of fistulæ not unfrequently undermines the morbid tissues. The structures in the posterior mediastinum and prævertebral regions are often affected, and the bodies of the vertebræ may become carious. Dr. Israel makes his third group of cases include those in which the disease begins primarily in the intestinal canal. In some of the cases the foci of the disease are widely disseminated. The liver, spleen, muscles of the back, and muscular substance of the heart have been shown on post-mortem examination to have numerous centres of actinomycosis. Large abscess cavities may form behind the peritoneum as well as behind the pleura, and these may communicate by many perforations of the diaphragm. The symptoms necessarily depend chiefly on the localisations of the disease as well as on its rate of progress, and present therefore extremely varied clinical pictures. Dr. Israel's work contains an account of thirty-eight cases, which number includes all that have hitherto been recorded.—*Lancet*.

[Dr. J. B. Murphy, of Chicago, reported two cases in the human subject, before the Chicago Medical Society (*Chicago Medical Journal*, March, 1885). In both the disease attacked the lower jaw, and the peculiar sulphur-colored granules were readily recognized. Both patients recovered. These are probably the first cases which have been recognized on this continent]—ED. LANCET.

TREATMENT OF RINGWORM OF THE SCALP.—The following is a very simple and effectual method of treating ringworm of the scalp.

The child affected is made to sit down before a wash basin half filled with warm water. A folded towel is first of all tied around the child's forehead, in such a way that no fluid poured on the head can trickle into the eyes.

It is best to cut the hair short all round the affected part. If there be many spots of ringworm, the whole head may be closely cropped. Have ready a two-ounce bottle of common spirits of turpentine, an ounce bottle of tincture of iodine, a camel's hair brush, and cake of 10 per cent. carbolic acid soap.

While the child bends forward over the basin, the spirits of turpentine is freely poured over one or more spots at a time, the forefinger being used to rub the turpentine well into the scalp. Almost immediately the dirt and greasy scabs disappear, and the short broken hairs are seen to stand up

like bristles. Generally, in about three minutes time the child cries out "Oh, it nips!" and we know the turpentine has penetrated deeply. Immediately the piece of carbolic acid soap is rubbed well into the parts which have been acted on by the turpentine, and warm water is freely applied to make this soap into a lather, by which means the head is well washed, and soon appears to be beautifully cleaned. The smarting, such as it is, quickly disappears. The head is then well dried with a towel. Common tincture of iodine, in two or three coats, is now painted well over the affected parts, and allowed to dry. As soon as the hair is dry, some carbolic oil (1 in 20) is rubbed through the hair to catch such spore as may be there.

This treatment, applied every morning, or morning and night in very bad cases, generally cures the worst cases in the course of a week. During the last five years I have used no other method of treatment. The explanation of its success is as follows: common spirits of turpentine is a powerful germicide, but is a still more powerful solvent of the sebaceous or greasy matter of the scalp, and it rapidly penetrates into all the epithelial structures of the scalp, the affected hairs included, and clears the way for a more powerful germicide, namely, the tincture of iodine.

It is an interesting chemical fact that spirits of turpentine, or more correctly, oil of turpentine, is a powerful solvent of iodine. This quickly destroys the fungus of ringworm. If tincture of iodine be applied to the spots which have been treated as above, first with the spirits of turpentine and then washed with carbolic acid soap and water, it finds its way down into the epithelial structures, and into the hair-follicles, following the course which the spirits of turpentine has taken. It is of no use to apply watery solutions of germicides until the sebaceous or greasy matter of the scalp has been first removed.

In some severe cases I have used a solution of iodine in turpentine, ten grains to the ounce, instead of the tincture of iodine, after the head has been washed and cleaned; but in most cases the use of tincture of iodine, after the part has been acted on by spirits of turpentine as above described, is quite sufficient to destroy the disease.

Ringworm of other parts of the body may be treated with spirits of turpentine and tincture of iodine in the same way. One great advantage of this treatment is that it may be used on the head of the youngest child, and causes little or no distress at any time.—*Brit. Med. Journal*.

RAPID ANÆSTHESIA BY ETHER—Dr. A. F. Müller says in the *Med. News* April 4th: "The following method of rapid anæsthesia by ether was suggested to me seven or eight years ago by a thought that the great length of time often consumed in

etherizing patients was due to the fact of the frequent interruptions necessary to replenish the cone or towel used for the purpose, and the consequent partial recovery of the patient. To obviate the difficulty and obtain a continuous flow of pure ether vapor, I have made an apparatus, consisting of the two valves of a rubber football sewed together at the edges and connected by a tube with a bottle containing ether, which is plunged into a bucket of hot water. Ether boils at 98°, and vapor passes over steadily and rapidly, and is inhaled by the patient, whose face is covered by the inhaler, protected by a clean towel.

The result has been surprising, as will be seen by the following cases, all etherized by this method within the last three months at the Germantown Hospital. In none of the cases was there nausea previous to anæsthesia; one at least came to the house the morning of the operation having eaten a hearty breakfast. In most cases no struggling, and if so, only slight; no stage of excitement. In cases that require only a few moments for operation, the patient wakes up as quickly as after nitrous oxide. After patient is etherized, the amount passing over can be regulated by a stop-cock at the bottle end of the tube.

The apparatus I have used is very crude, made only for the purpose of experiment, and I am having an improved one made, which I hope will be more satisfactory in its details."

The quantity of ether used to produce complete insensibility in no case exceeded three ounces; in some it was less than an ounce and a half. Dr. Müller reports 18 cases in which unconsciousness was produced in from 30 seconds to 2 minutes.—*Maryland Med. Journal*.

KUSSMAUL'S COMA.—Dr. Saundby read a paper on Kussmaul's coma before the Midland Med. Society, based upon two recent cases. He ascribed its symptoms, drawing attention to the peculiar character of the dyspnœa as constituting a distinguishing feature of pathognomonic significance. He especially insisted upon the fact that this form of coma was not restricted to diabetes, one of the cases related being an example of its occurrence in advanced renal disease. He referred to the various theories which had been advanced to explain it, and stated precisely the exact position of the acetœmia question. He explained the methods used for testing the acetone, and showed Nobel's test with nitro-prusside of ammonia. In his opinion, the symptoms were due to the action of some poison nearly allied to acetone. He referred to Minkowski's suggestion that they might be the result of de-alkalization of the blood from the presence of some acid in great excess. After discussing the predisposing and exciting causes and the diagnosis, he pointed out that it was not invariably fatal. Treatment in the earlier stages should be

elimatory, by purgatives, if the bowels could be got to act, and later on the intravenous injection of a neutral saline solution should be tried. The result in one case was to restore animation for the time; and where recovery was possible, more permanent results may be expected.—*Am. Med. Digest*.

RESECTION OF THE CLAVICLE FOR SARCOMA.—An interesting surgical case has been placed on record by M. Polaillon. The patient was a girl aged sixteen, in whom a swelling of the outer end of the right clavicle was first noticed eighteen months ago, and had gradually increased in size. There was not much interference with the movements of the arm, and but little pain. The tumour was about the size of the fist, of bony consistence, and lobulated in outline. The skin over it was normal. There were no signs of compression of the brachial nerves or vessels. The lymphatic glands were healthy. Careful examination showed that the tumour did not pass beyond the limits of the expanded clavicle in any direction. The operation was performed on Jan. 29th under the spray. A horse-shoe shaped incision was made through the soft tissues, and the flap turned inwards, its base being at the neck of the patient; the clavicle was cut through at the insertion of the sterno-mastoid in the inner third of the bone, and then disarticulated at its outer extremity. In order to isolate the tumour the fibres of the trapezius and deltoid were cut through at their insertion into the clavicle. Antiseptic dressings were applied. The patient did well, and left the hospital six weeks after the operation. There was but little deformity, and the movements of the arm were perfectly preserved.—*London Lancet*.

THE TREATMENT OF ASTHMA.—According to Dr. Rodet, the best means of overcoming a paroxysm of asthma consists in subcutaneous injections of morphia and inhalations of iodide of ethyl. Twelve drops of the latter, poured on a handkerchief and inhaled, procure almost immediate relief. The different papers and cigarettes which have been recommended are worthy of a trial, a change of air and occupation is often essential. In catarrhal asthma, the treatment must be directed against the bronchitis and laryngitis, which are often benefited by a stay in a warm climate. According to M. Hardy, very good results are sometimes obtained by means of a blister applied to the thighs or arm. In nervous asthma, bromide and iodide of potassium are the most useful remedies, especially the latter. Gymnastics and baths of compressed air can also be recommended.—*Journal de Medecine de Paris*, No. 25, 1884.

THE AFTER-TREATMENT OF SCARLET FEVER.—Mr. George Smith, of Somerset, England, in a

short note on this subject in a recent number of the *Bristol Medico-Chirurgical Journal*, gives a plan of treatment of the desquamative stage of scarlet fever which has been quite successful in his hands, and which might be followed with good prophylactic results in every case. It is well known that in this stage there is very great danger that the disease may be conveyed from a patient to a healthy person, even several hundred miles away.

To obviate this danger, he has been in the habit for several years of having his patients sponged over the whole surface of the body twice daily. The sponging is begun, as a rule, about a week after the appearance of the eruption, and is continued until the desquamative stage is completed. The material with which the patient is sponged is a mixture of one ounce of oatmeal to one pint of boiling water; this solution should be made fresh each day, and used while tepid, or at such a temperature as may be comfortably borne by the back of the hand. The gluten of the oatmeal sticks the scales of the skin to one another and to the surface of the body, which allows of their removal without the usual risk of infecting the atmosphere or clothing; thus greatly lessening the risks of spreading the disease. The gluten also fills the cracks in the new skin and protects it from the cold; which diminishes the risk of the œdema which so frequently follows scarlatina.—*Am. Med. Association Journal*.

NAPHTHOL FOR ITCH.—Prof. Hardy publishes the following formula in the *Union Medicale*: Naphthol, 10 parts; vaseline, 100 parts. The powdered naphthol is to be dissolved in half its weight of ether. This solution is to be mixed with a portion of vaseline, and heated to 30° or 40° C., until the ether has been entirely evaporated, when the rest of the vaseline is to be added, and the mass carefully triturated. The homogeneous ointment thus obtained is to be kept from the access of air. It may be applied at any stage of itch, and whether it is or is not complicated with other eruptions. The duration of the treatment varies from 10 to 15 days.—*Med. and Surg. Reporter*.

A NEW TREATMENT OF EPITHELIAL CANCER.—Experiments now in progress, under the supervision of Dr. J. E. Garretson, at the Oral Hospital of this city, show a wonderful curative value in the treatment of epithelial cancer with the use of epiderm secured from the horse by means of a curry-comb, the treatment being nothing more complex than keeping a sore continuously covered with the ash-colored powder thus obtained. The horses are to be washed over night and curried with new curry-comb in the morning. After pick-out the hairs the powder is ready for use. When horse epidermis is not to be obtained, the scales may be scraped by means of a knife-blade from the human arm or leg.—*Med. and Surg. Reporter*.

STRICTURE.—In urinary obstruction, due to prostatic hypertrophy or thickening of the mucous membrane of the urethra, Professor A. B. Palmer says that relief can frequently be obtained, and the evils of catheterization avoided, by simply making the stream of urine act as a hydrostatic dilator in its passage. This can be readily done during micturition by compressing the urethra between the thumb and fingers so that no urine can escape. An effort is to be made at the same time to forcibly empty the bladder. The result is that the urethra is gently and uniformly distended without pain. This distension can be obtained and sustained at will, and in a majority of cases, if daily repeated, will soon be followed by the power of almost completely emptying the bladder, with a fair and often a full stream.—*Medical Bulletin*.

JABORANDI IN OBSTINATE HICCOUGH.—Pagensteher (*Contrib. f. d. ges. Therap.; Bull. gén. de Therap.*) reports a case of hiccough which had resisted every known remedy, including the bromides, morphine, chloroform, and electricity. The patient's diaphragm contracted in the most violent manner about twenty or thirty times a minute, and he had been unable to take any nourishment for three days. After receiving four grains of jaborandi-leaves, in the form of a decoction, he had a profuse perspiration, after which the hiccough was completely checked.—*New York Med. Jour.*

To render blood more coagulable—when we have effusions of the same into cavities and so cannot ligate the bleeding orifices, Prof. Gross advises—

R.	Acid. gallici.	gr. ij	
	Digitalis foliorum,		
	Ergotin.,	aa	gr. j
	Opii,		gr. ss. M.
SIG.	—Ter die.		

When the stomach is irritable, so that medicines cannot be retained, and if it should be necessary to purge the patient, Prof. Gross recommends the following injection, should there also be much tympany: Oil of turpentine, ʒss, rubbed up with the yolk of one egg, then add castor oil, ʒiiss, warm water, Oj. To be used as an injection.—*Col. and Clin. Record*.

PRURITIS ANI and the distressing itching of urticaria and mosquito bites can be much alleviated by local applications of methol. It may be used by rubbing the methol pencil lightly over the surface, or by dissolving a small amount in alcohol and bathing the part.—*Lancet and Clinic*.

LITTLE BOY: "Please I want the doctor to come and see mother." **Servant:** "Doctor's out. Where do you come from?" **Little Boy:** "What! Don't you know me? Why, we deal with you. We had a baby from here last week!"

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHER, 23 Rue Richer, Paris.

TORONTO, JUNE, 1885.

The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

THE AMERICAN MEDICAL ASSOCIATION

The thirty-sixth annual meeting of the American Medical Association was held in New Orleans April 28th and following days, under the presidency of Dr. Campbell, of Augusta, Ga. Although the attendance was not as large as was anticipated, the meeting was, upon the whole, a very interesting and profitable one. The address of the learned President was an able effort, and was listened to with profound attention. He referred to the honor conferred on the State he represented, and eulogized the long list of illustrious men who had guided the destinies of the Association, making special reference to Gross, Sims and others. He also paid a high compliment to Dr. N. S. Davis, of Chicago, who is generally regarded as the father of the Association, and who has faithfully watched over its interests for many years. He also alluded to the assured and satisfactory success of the *Journal of the Association*. He next referred to medical politics, so to speak, such as forensic medicine, the medical witness, the medical expert, etc., and suggested that a new Section should be formed, to which all papers, questions and reports in regard to the relations of medical men to legal tribunals might be referred.

The address on medicine was delivered by the chairman, Dr. Didama, of Syracuse, N. Y. Instead of giving a summary of the progress of this department during the past year, as is

required by the by-laws, he alluded to two topics merely as having acquired special prominence, viz: the comma bacillus and cocaine. In speaking of the relation of the former to cholera he made a remark which we are sure all will endorse, "The results of Koch's experiments were negative so far as treatment was concerned, but let us labor and wait, and in the meantime direct a little more attention toward prophylaxis and therapeutics." The subject of the address on obstetrics by the chairman, Dr. Sutton, of Pittsburg, Pa., was "The History of Ovariectomy." This address is published in the present issue of the LANCET, and will be found very interesting and instructive reading.

The presentation of the report of the Committee appointed last year to make arrangements for the forthcoming meeting of the International Medical Congress in 1887, occasioned some lively discussion. The objections urged were that several "new code" men had been appointed to important positions as officers of the Congress and its sections, and that several States and Territories in the South and West were entirely unrepresented. The result was the appointment of thirty-eight additional members to the original Committee, with power to revise and correct the list of officers previously announced. It is to be hoped that the action of this monster committee will not jeopardize the success of the Congress. The *Boston Med. and Surgical Journal* in commenting on the action of the association says that the Congress is "more interested in medical science in the abstract than in local medical politics," and "that the "new code" nonsense had best be allowed to pass into ready oblivion, and not be given fictitious importance by further discussion."

The report of the committee on publication showed that the "Journal" was free from debt, had about 4,000 subscribers and promised soon to be the foremost in the United States. Dr. Davis of Chicago, was unanimously requested to continue as Editor. The social side of the meeting was all that could be desired. The members enjoyed the generous hospitality of their chivalrous brethren in the South to the full. His many friends in Canada will be pleased to learn that Dr. Brodie of Detroit, has been chosen president for the ensuing year. The next meeting will be held in St. Louis, on the first Tuesday in May 1886.

MISDIRECTED UTERINE EFFORT.

Every experienced accoucheur has met cases of misdirected uterine expulsive force. Two recent cases of this nature which have come under our observation, are the occasion of the following remarks. In both cases the women had borne several children. Labor in each case had always been both protracted and severe, continuing from twenty-four to forty-eight hours. Medical aid had invariably been called. In both cases, on arrival, the os was found fully dilated. The presentation was normal, and the head engaging the upper strait. The pelvis, in each case, was roomy and offered no unnatural obstruction. The pains were severe and attended with strong expulsive effort—in fact, of the character which usually marks the termination of a severe case of labor. A casual survey of the situation might easily have led to the prediction of a speedy delivery. A little waiting and a more critical examination, however, exhibited things in a different light. It soon became apparent that, notwithstanding the powerful uterine contractions, and the consequent suffering, little or no advance was made. From this it was evident that something was wrong. Placing the hand on the abdomen during the partial interval of pain, it was found to be prominent, and conical in shape, the apex pointing diagonally over the pubes. During a pain, this cone, with the hand resting on it, was carried forward over and beyond the pubic arch, thus doubling the foetus upon itself, and showing that more force was directed to this point than to the outlet. Every obstetrician occasionally meets a case of which the above is more or less typical. The os is either dilated or dilatable; the presentation normal; the pelvis roomy, and the soft parts offering no apparent obstruction; the pains are severe, and the patient makes powerful expulsive efforts. All this, and yet hours of patient waiting and suffering are marked by no perceptible progress. The unfortunate woman is in great agony, and nature is fast becoming exhausted. Friends are in despair, and demand that “something” be done. The situation is a trying one to all concerned. Of course these remarks apply more or less forcibly to all cases of protracted labor irrespective of cause.

Having discovered the cause of delay, the next thing to do is to find and apply a remedy. Chlo-

roform, morphia, and chloral, as everybody knows, are all agents well fitted to relieve the suffering and also to promote normal uterine contraction, where there is a deviation from this condition. In the cases under notice, chloral was the agent selected. About twenty grains were administered the first dose, and ten grains at regular intervals afterwards. A sheet was folded to the width of an ordinary abdominal bandage. This was passed under the patient, and crossed over the abdomen. The upper end was handed to the nurse, sitting at the opposite side of the couch, while the lower end, which embraced the *cone*, was held by the accoucheur. The nurse was directed to make no traction, but simply to retain a firm hold. The force exercised consisted mainly in *resisting* the downward and forward movement of the prominent uterine segment or cone. The pains, which had been insufferable, and without distinct interval, became more tolerable, having intervals so well marked as to permit quiet and needed sleep. The woman, who a little while before was in the utmost agony and despair, was now quiet and hopeful, and thus the case rapidly progressed to a happy termination. In each case the duration of labor was reduced to less than one-third that of former labors.

These cases are not presented on account of anything striking or novel, nor yet on account of the line of management pursued. The object rather is to put the profession in remembrance of the great fact that much can be done to shorten the duration of labor and to relieve the pangs of maternity. These surely are objects worthy the attention of every physician endowed with proper feelings, and no apology should be deemed necessary for even a frequent reference to them.

FOOD FOR INFANTS.

The many predictions concerning the possible advent of cholera during the present summer, are receiving due attention from medical men and boards of health in our large cities, and the result of such attention cannot fail to prove highly beneficial to the public health. But should we have a very hot summer, as is not improbable, there will be the usual “Slaughter of the innocents,” in the large cities, and we think it important that the attention of the profession should be called to the

fact that three-fourths of the cases of sporadic infantile cholera are initiated by carelessness in the selection of the food given to bottle-fed infants. If from the first of June to the first of October every mother would see to it that her infant was fed with easily digested and in every respect suitable food for hot weather, we believe we should have to record at the close of this much dreaded summer a decrease instead of an increase in infant mortality.

Dr. H. Von Ziemssen, writing on *Sporadic Cholera*, in Vol. vii. of the Cyclopaedia of Medicine, says:—"Regulation of the diet constitutes in fact the principal method of treatment of sporadic cholera and particularly cholera infantum. When mothers' milk is insufficient Liebig's Food or Nestle's Lacteous Farina are *alone to be recommended*. The latter is *especially* commendable because the physiological relations of the infantile digestive organs, particularly the lack of notable salivary and pancreatic secretions are taken into account in this fabrication, the starch contained in it having been transformed into dextrine." It should also be borne in mind that infant foods are also well adapted to the nourishment of invalids of all ages.

RAREFIED AIR IN PHTHISIS.

Experiments have been made from time to time in order to determine the effects of rarefied air upon respiration. The results generally show that an elevation sufficiently great to cause a diminution of the barometric pressure to one-third of its normal value is necessary to produce the desired effect upon the respiration, viz: to render it more frequent and profound. Experiments have been made with dogs by subjecting them to great variation of air pressure; but no change in the respiration was observed until a height was reached which showed considerable rarefaction of the air. It would thus seem that the influence of mountain air on the respiratory apparatus, which some physicians covet for their consumptive patients, is not very decided until heights of at least 5,000 or 6,000 feet are reached. An interesting result obtained by these experiments was that at very low pressures (about ten inches of mercury) the ultimate effect was a diminished nutrition of the tissues.

The results are of value in determining the curative properties of mountain air upon weak and

diseased lungs. But they are far from conclusive. Similar experiments were made in 1880 by Dr. Marcet with himself and a scientific companion at Courmayeur (3,945 feet) and the Col du Géant (11,030 feet high). In ascending from Yvoire to Courmayeur—a vertical distance of only 2,715 feet—the relative atmospheric humidity was lowered by 31 per cent. for the higher station, and the mean weight of the carbonic acid expired by the two experimenters was found to be in excess at the higher station over the lower by more than 8 per cent. This clearly shows the influence of even moderate altitude above sea level, coupled with increased atmospheric dryness, towards promoting combustion in the human body. At the high station of the Col du Géant, over 11,000 feet, the rate of breathing was accelerated by more than 39 per cent. in Dr. Marcet's case, and over 25 per cent. in his companion's. Although in the rarefied air of high levels the body makes more carbonic acid, it exhales it much more rapidly than under the lower pressure of the plains, and the augmented activity of the respiratory organs necessitated by breathing rarefied air is in many cases the chief curative agency of mountain districts.

ONTARIO MEDICAL ASSOCIATION.—The Association is to be congratulated on the large number of papers promised for the meeting in London on the 3rd and 4th inst. In fact it will scarcely be possible to get through with them in two days. In addition to the special subjects in medicine, surgery and obstetrics referred to in our last issue, the following papers are announced: Drs. Buck—"Sanity;" Bray—"Cæsarian Section;" Edwards—"Placenta Previa;" Beemer—"Brain Exhaustion;" Waugh—"Infantile Paralysis;" Fraser—"Continued Fevers;" Penwarden—"——"; Graham—"Mitral Stenosis;" Groves—"Urinary Calculi;" Arnott—"Diet in Disease;" Campbell—"Locomotor Ataxia;" Ovens—"Trifacial Neuralgia;" McKechnie—"Pericarditis;" McLay—"Cystitis;" Harrison—"Foreign Bodies in Larynx;" Aylesworth—"——"; Moorhouse—"The Germ Theory with specimens;" Worthington—"Lingual Neuralgia;" Duncan—"Warburg's Tincture in Canadian Practice;" Murray—"Uterine Hemorrhage after Abortion;" White—"Straight Splint in Treatment of Fractured Elbow of Childhood;"

Howe—"Effects of Cocaine on the Eye" and "The Blindness of Pregnancy;" Atherton—"Intestinal Obstruction;" Thorburn—"Passive Motion in after-treatment of Fractures;" Oldright—"Pathological Specimens;" Adam H. Wright—"Treatment of Abortion;" Yeomans—"Comp. Fracture of the Patella;" McPhedran—"Lymphadenoma" (Hodgkin's Disease); Henderson—"Pulmonary Cavities;" Dupuis—"Multiple Abscess of Liver.

In addition to the numerous papers a "Question Drawer" is to be instituted, in which members may place any question coming within the sphere of the Association. This will be opened and the questions read by the Secretary each afternoon and evening session and submitted for discussion. We hear that quite a number of our *confrères* from Montreal, Buffalo, and Detroit are invited and will be present.

IODINE IN THE TREATMENT OF GOITRE.—The injection of iodine into the thyroid body for the cure of goitre seems to be very generally practiced by leading surgeons, with much greater success than the treatment by excision. The only danger in the former plan is that of sudden death, which, although it rarely occurs, is extremely serious. As compared with excision the danger is trifling, hence it is much more preferable, provided it is curative. The safest place to make the punctures is, on either side, between the jugular vein and the sterno-mastoid muscle. The injections should not be confined to one spot; and should be repeated about once a week for several months. The following mode of injecting is recommended by Dr. W. J. Tivy, in the *British Medical Journal*:

"Having drawn up from thirty to sixty minims of tincture of iodine into the syringe, before screwing on the needle, adjust the needle to the syringe, and force a few drops of the iodine in the syringe through the needle so as to effectually expel all air from the needle itself; and having well oiled it with carbolic oil (one in twenty), push the needle to the depth of about an inch well into the goitre, and, raising the syringe higher than the point of puncture, so as to avoid injecting air, should any remain in the syringe, slowly inject the iodine; when this has been done, rapidly withdraw the needle, pinching up the skin around it to prevent any escape of the iodine."

The iodine treatment by injecting goitrous hypertrophy is one that requires time, patience and perseverance to accomplish a cure; but it is much safer than extirpation, and it is evidently superior to treatment by the application of iodine externally and iodide of potassium internally.

HEART BEATS.—Dr. W. B. Richardson of London, says he was recently able to convey a considerable amount of conviction to an intelligent scholar by a simple experiment. The scholar was singing the praises of the "ruddy bumper," and saying he could not get through the day without it, when Dr. Richardson said to him: "'Will you be good enough to feel my pulse as I stand here?' He did so. I said: 'Count it carefully; what does it say?' 'Your pulse says 74.' I then sat down in a chair and asked him to count it again. He did so, and said: 'Your pulse has gone down to 70.' I then lay down on the lounge, and said: 'Will you take it again?' He replied: 'Why, it is only 64; what an extraordinary thing!' I then said: 'When you lie down at night, that is the way nature gives your heart rest. You know nothing about it, but that beating organ is resting to that extent; and if you reckon it up it is a great deal of rest, because in lying down the heart is doing ten strokes less a minute. Multiply that by sixty, and it is 600; multiply it by eight hours, and within a fraction it is 5,000 strokes different; and as the heart is throwing six ounces of blood at every stroke, it makes a difference of 30,000 ounces of lifting during the night. When I lie down at night without any alcohol, that is the rest my heart gets. But when you take your wine or grog you do not allow that rest, for the influence of the alcohol is to increase the number of strokes, and instead of getting this rest you put on something like 15,000 extra strokes, and the result is you rise up very seedy and unfit for the next day's work till you have taken a little more of the 'ruddy bumper,' which you say is the soul of man below."

POTT'S DISEASE IN YOUNG CHILDREN.—As a substitute for the plaster-of-Paris jacket Dr. H. C. Wyman, of Detroit, has devised a method of treatment which presents many commendable features. It is substantially a moveable jacket, and its application is as follows: The child being placed in such position that the spine is extended to nearly the normal limit; a piece of cotton flannel large

enough to cover, say one-third of the circumference of the trunk, is laid on the back. A sheet of absorbent cotton having been placed over this, a cheese-cloth bandage six inches wide and several yards long, with the meshes carefully filled with plaster-of-Paris, is dipped in water and folded length-wise over the whole. When rubbed smooth with the hand so that it is perfectly adapted to the contour of the parts, a bandage is applied around the trunk, with figure-of-eight turns about the shoulders and pelvis, and the plaster allowed to set. The jacket thus constructed is in the form of a splint, and can be removed every night for the purpose of permitting massage.

MEDICAL COUNCIL ELECTION.—The following are the names of the newly elected members of the Ontario Medical Council :

Territorial Representatives.—Drs. J. L. Bray, Western and St. Clair ; E. G. Edwards, Malahide and Tecumseth ; R. Douglas, Saugeen and Brock ; J. A. Williams, Gore and Thames ; J. Russell, Burlington and Home ; J. H. Burns, Midland and York ; R. B. Orr, King's and Queen's ; A. Ruttan, Newcastle and Trent ; H. W. Day, Quinte and Cataraqui ; J. G. Cranston, Bathurst and Rideau ; D. Bergin, St. Lawrence and Eastern ; ———, Erie and Niagara.

Collegiate Representatives.—Drs. J. W. Rosebrugh, University of Victoria College ; V. H. Moore, Queen's College ; W. T. Harris, Trinity College ; H. H. Wright, Toronto School of Medicine ; F. Fowler, Royal Col. Phys. and Surgs., Kingston ; W. B. Geikie, Trinity Medical School ; A. G. Fenwick, Western Univ., London.

Homœopathic Representatives.—Drs. Geo. Logan, G. Henderson, C. T. Campbell, E. Vernon, G. E. Husband.

PERSONAL.—Dr. D. J. Grant, of Woodbridge, Ont., on the eve of his removal from the village, was presented with a beautifully engraved silver water pitcher, and Mrs. Grant with a massive silver salver, with suitable inscriptions. An address expressive of the high esteem in which both the Dr. and Mrs. Grant were held by the citizens, and best wishes for their future prosperity and happiness, accompanied the presentation. Many of the leading citizens were present, and all spoke in flattering terms of the Doctor's sterling qualities and of his successful public and professional career. We

heartily endorse the action and sentiments of his many friends in Woodbridge, and trust that he may be long spared to be a blessing to those among whom he may minister in the future.

TORONTO UNIVERSITY CONVOCATION.—The following gentlemen received the degree of M. B. in this University. J. H. Howell, *Gold Medallist* ; L. Cars, M. R. Saunders, H. N. Hoople, *Silver Medallists* ; C. H. Britton, F. W. Cane, J. D. Courtney, W. J. Greig, A. B. Kinsley, C. A. Krick, D. J. Minchin, D. Poole, M. Staebler, A. S. Thompson.

M. D., J. Bray.

SCHOLARSHIPS.—*First Year*, S. Cummings and J. A. Palmer. *Second Year*, F. P. Bremner and A. Ego. *Third Year*, A. W. Bigelow and G. A. Peters.

TRINITY UNIVERSITY.—The following is a correct list of the successful candidates in the primary examination :—J. R. Logan, H. H. Hawley, John McLurg, James McLurg, J. H. Hamilton, W. R. Nichols, J. M. Thompson, D. McLaughlin, A. E. Yelland, T. F. Campbell, C. R. Staples, J. E. Midgeley, B. Hawke (*Honors*), T. G. Lundy, W. J. Stevenson, W. Giles, H. C. Phillips, G. S. Pater-son, J. H. Hoover, O. J. Niemeire, F. E. Luke, J. A. Tuck, C. E. Thompson, J. C. Moffatt, D. Mc-Edwards, J. W. Hart, T. S. Philp, T. Primmer, W. F. Graham, W. I'anson, M. Maxwell, A. E. Mac-kay, J. P. Shaw, D. A. Kidd, H. R. McCullough, W. A. Fish, D. M. Gordon, J. J. Soden, C. A. Toole, D. S. Thompson, J. C. C. Grasett, S. H. Irwin, D. Kester, H. Blair, J. W. Shillington, T. Wilson, G. Gordon, S. T. Bell, R. A. Barber, H. S. Bingham, H. J. Caldwell, J. G. White.

BISHOP'S MEDICAL COLLEGE, MONTREAL.—The following gentlemen have passed their examination in this University :—M.D., C.M.—F. R. England, "*Wood*" and "*Nelson*" *Gold Medallist* ; J. B. Saunders, *Chancellor's Prize* ; C. E. Parent, C. R. Gillard.

PRIMARY.—A. F. Longway, *David Scholarship* ; T. J. Groulx, *Practical Anatomy Prize* ; R. Campbell, A. P. Scott.

CORROSIVE SUBLIMATE IN CATARRH.—Bichloride of mercury, in a solution of one grain to the pint of water, to which two ounces of cherry laurel may be

added, is recommended in the treatment of inflammatory conditions of the nose and throat, with profuse muco-purulent secretion. Crusts that may be present and tenacious mucus should be removed from the surfaces, which should then be sprayed with an atomizer provided with suitable tubes. Dr. J. N. Mackenzie regards it as a most valuable disinfectant in ozœna and fœtor of the breath from pharyngeal disease. He found it successful in his own case in abating an acute coryza, and had good results in treating chronic nasal catarrh.

NEW YORK POLYCLINIC.—The Winter Session of the New York Polyclinic ended on Saturday, May 30th. The number of physicians who have attended the clinics since Sept. 22nd, is over 200. The Summer Session opens Monday June 1st, and will continue to Sept. 12th. The following clinics will be held each week: Gynæcology 12, Disease of Children 6, Surgery 8, Diseases of the Skin 6, Diseases of the Chest, General Medicine and Diagnosis 6, Diseases of the Eye 6, Diseases of the Throat, Nose and Ear 6, total 50. In addition Obstetric cases will be given to the class and a course in urinary analysis. The Laboratory of Pathological Histology will be open all Summer.

ATROPINE IN EPILEPSY.—David ("Lyon méd.") *N. Y. Med. Jour.*, administers to epileptic patients twenty grains of bromide of ammonium, and at the same time gives fifteen thousandths of a grain of sulphate of atropine night and morning. After this treatment has been continued for six months, he directs that two of the following pills be taken daily for at least a year:

Valerianate of zinc...	$\frac{2}{3}$ grain;
Extract of belladonna.....	$\frac{1}{10}$ "
Arsenious acid.....	$\frac{1}{10}$ "
Extract of gentian.....	q. s.

TONIC AND DIURETIC.—The following has been highly recommended in anasarca and other affections demanding similar treatment:

R Ferri sulph.	3i.
Pot. acetat.	3ij.
Sq. scillæ.	3ss.
Ext. digitalis fld.	5i.
Spt. juniper, co. ad	3viii—M.

Sig. A tablespoonful in a little sweetened water three times a day.

PNEUMOTHORAX FOR HÆMOPTYSIS.—At a meeting of the Clinical Society of London, Dr. Cayley, reported a case of hæmoptysis treated by producing pneumothorax (*Lancet*, May 16th.) The patient was much reduced by repeated bleeding, and it was determined to admit air into the pleural cavity with the view of exercising atmospheric pressure and diminishing the circulation through the collapsed lung. The hæmorrhage was arrested, but the patient was too much reduced, and died of syncope, on the fifth day after the operation.

UNIQUE CASES.—Dr. Belfry of London, Ont., reports the case of a child which weighed 18½ lbs. at birth, and measured 23¾ inches in length. He also reports the case of a woman 42 years of age, now at the menopause, who is cutting two new incisor teeth. Her permanent incisors decayed and were extracted last year. She is a weakly woman; had a tumor removed from the abdomen 15 years ago in Manchester, England, and a discharging sinus has continued ever since. She is also suffering from caries of the os innominatum. Both cases are unusual if not unique.

MELLIN'S FOOD.—Among infant foods which have become popular with the profession may be mentioned Mellin's Food. The manufacturers, Messrs. Doliber, Goodale & Co., of Boston, are to be congratulated on the recognition of their exhibit of this Food at the New Orleans exhibition, the judges awarding it the first prize, a gold medal, as the best food for infants and invalids.

CHOLERA INOCULATION.—It is reported that between four and five thousand persons in Valencia, Spain, have been inoculated with cholera microbes by Dr Ferràn. The results are said to have been successful, and the epidemic is disappearing. A commission has been appointed by the British Government to investigate Dr. Ferràn's experiments.

INTOLERANCE OF POTASSIUM IODIDE.—Many persons are entirely unable to take even very small doses of iodide of potassium, without producing unpleasant effects. To overcome this it is recommended to combine with it ordinary doses of fluid extract of belladonna. The addition of a small quantity of fluid extract of liquorice will also cover the taste and render the mixture more palatable.

CROTON CHORAL HYDRATE.—This remedy, for-

merly so much relied upon in the treatment of painful affections of the 5th nerve, is now much used in the treatment of neuralgic dysmenorrhœa, sciatica, lumbago, etc. Five or six grains in glycerine and water may be given three times a day.

VOMITING OF PREGNANCY.—The application of ether spray over the epigastrium is recommended in the vomiting of pregnancy. Immediate benefit has been derived from its use where drugs of all kinds have failed to afford relief.

CORRECTION.—In our April issue, page 239, the address of J. Ellwood Lee, manufacturer of Levis' Splints, was incorrectly given. It should have been 425 Walnut St., Philadelphia.

TRINITY MEDICAL SCHOOL.—The Fellowship Diploma of Trinity Medical School has been formally recognized by the Royal College of Physicians, London, Eng., and also by the "Triple" Examining Board of Edinburgh. This Diploma is now recognized by all the licensing bodies in Great Britain.

The death of Prof. Henle, of Berlin, the celebrated anatomist and physiologist, on the 18th ult. at the advanced age of 74 years, is announced. Also Prof. Panum of Copenhagen.

CORONER.—Dr. G. H. Bowen, of Seeley's Bay, Ont., has been appointed Coroner for the Counties of Leeds and Grenville.

We regret to announce the death of Mrs. Dr. Workman of this city, at the age of 72 years.

This estimable lady sustained the sacred and endearing relationship of wife and mother, for nearly half a century, and embellished a life devoted to its duties with all the graces of the Christian character. Dr. Workman has our deepest sympathy in his great bereavement.

Books and Pamphlets.

INHALATION TREATMENT OF DISEASES OF THE ORGANS OF RESPIRATION. By Arthur Hill Hassall, M.D., Lond. Longman & Green, London. Hart & Co., Toronto.

Dr. Hassall of San Remo, in the Western Riviera, has in the above volume furnished the profes-

sion with a succinct, but sufficiently exhaustive notice of the various requisites to be fulfilled by the very numerous forms of Inhalers that have from time to time been placed in the market, as also of the adaptability of the inhalation treatment for certain diseases of the organs of respiration. The subject is treated in seven chapters under the following heads: 1. Entrance of medicaments into the organs of respiration. 2. Principles concerned in the volatilization and inhalation of the medicaments. 3. The apparatus to be employed. 4. Inhalation chambers. 5. The quantities of the medicaments, the manner, frequency and duration of the inhalations. 6. The medicaments employed in inhalation. 7. The various diseases in which benefit may be expected to be derived from this mode of treatment. At the Continental spas it would seem to be the practise to make extensive use of inhalation chambers, the apparatus for which the author describes as also the various substances used for sprays and vapors, in which chambers the patients will remain for hours, breathing the artificial atmospheres. The work is a valuable addition to the literature on the subject

A PRACTICAL TREATISE ON DISEASES OF THE EAR. By D. B. St. John Roosa, M.D., LL.D., Prof. of Diseases of the Eye and Ear, New York Post-Graduate Medical School, and President of the Faculty; Surgeon to the Manhattan Eye and Ear Hospital. New York: Wm. Wood & Co. Toronto: Williamson and Co.

We are pleased to receive the sixth edition of this standard work on the ear. The author is well known as a specialist on the ear, and the previous editions of his work have been greatly appreciated by the profession. The edition before us has been revised with great care, new matter has been added and the work contains much information of value to the general practitioner. We have great pleasure in recommending this book to our many readers, as a reliable guide to the diagnosis and treatment of affections of the ear.

A GUIDE TO THE DISEASES OF CHILDREN. By James F. Goodhart, M.D., F.R.C.P., Assistant Physician to Guy's Hospital. Philadelphia: P. Blakiston, Son & Co. Toronto: Hart & Co.

The scope of this work may be defined by the following extract from the author's preface: "I have not considered it my function to write a book on general medicine, but so far as possible, I have kept in view the diseases which seemed to be incidental to childhood, or such points in disease as appear to be so peculiar to, or pronounced in chil-

dren as to justify insistence upon them." In the second chapter will be found valuable hints for the young practitioner on the diet of children in health, as also in the third chapter for the treatment of derangements arising from faulty diet. The fourth treats on acute and chronic diarrhoea. The author impresses on the reader the importance of never missing an opportunity of examining the alvine evacuations, as the appearances will give valuable suggestions for treatment. The fifth treats on stomatitis, thrush, cancrum oris. The sixth on diseases of the digestive tract. The remaining chapters, forty-eight in all, deal with the various diseases of infancy and childhood in a manner at once interesting and instructive. Unqualified admiration must be expressed for the ability exhibited in arrangement, and for the clear and attractive form in which the author has placed his views before the reader.

THE ANNUAL AND SEASONAL MAPS OF THE UNITED STATES, by Prof. C. Denison, M.D., Denver, Colorado. Chicago: Rand, McNally & Co. Size of map 58 x 41. Price, mounted on muslin, \$5 00: on thick paper, \$3.00.

These maps illustrate the climate, temperature, humidity, cloudings, direction of winds, and physical features of the country. They will be found invaluable to physicians and others who have occasion to recommend or take advantage of change of climate. All the mineral springs and health stations in the United States are also referred to in the tables. We recommend these maps to the attention of the profession in Canada.

MEDICAL BOTANY OF NORTH AMERICA. By Lawrence Johnson, A.M., M.D. New York: Wm. Wood & Co. Toronto: Hart & Co.

The above-named work is a valuable addition to Wood's Standard Library of Medical Authors. As the title indicates the book treats principally of the botany of the plants whose therapeutic activity has placed them in the various text-books on *Materia Medica*. The work is illustrated with well executed coloured plates and wood cuts, and supplies a hitherto existing want, viz., a good manual on medical botany.

New Instruments.

COMBINED RECTAL AND INTRA-UTERINE IRRIGATOR.

Dr. J. S. Coleman, of Augusta, Geo., describes the following instrument in the *Brit. Med. Journal*, April 18th, '85:—In the *Medical Record* of New York, for May 10th, 1879, I presented to the medical profession the "Metro-clyst." I now desire

to call attention to a modification of this instrument, which makes it available for the diseases of the rectum and surrounding pelvic structures. The instrument is of hard rubber, and consists of a cylindrical frame or cage traversed by a central tube. This arrangement insures the easy exit of the injected fluid. Any ordinary syringe can, by means of rubber tubing, be attached to it. My preference in the use of hot water is for the siphon. Thanks to the genius of Dr. T. A. Emmett, we all now appreciate the indispensable value of hot water, in inflammation and as an hæmostatic. Though I have not yet had an opportunity of test-



ing the merits of this instrument in ovaritis, pelvic cellulitis, or peritonitis, I feel confident that we will find it one of our most efficient measures in combating these serious and obstinate forms of disease. So far as I am informed, Dr. J. R. Chadwick was the first to advocate the rectal use of hot water in the treatment of pelvic inflammations (*vide* his able and interesting paper in the *Transactions* of the American Gynæcological Society for 1880). To me it promises much in acute prostatitis, inflammation of the rectum, and internal hæmorrhoidal troubles. I have had most gratifying success from its use in a case of puerperal endometritis, and in one of rectal ulcers.

Births, Marriages and Deaths.

On April 30th, H. K. Kerr, M. D., to Anna E., eldest daughter of F. Franklin, Esq., both of Hammond, N. Y.

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Original Communications.

INTRA-UTERINE MEDICATION.*

BY J. ALGERNON TEMPLE, M.D., M.R.C.S., ENG.

Prof. of Obstetrics and Diseases of Women and Children
Trinity Medical College, Toronto.

It is well known to all the members of this Association that we are making a departure this year from our usual custom, and that instead of reading reports on the progress of the various branches of our profession within the past year, the chairman of each section has been requested to open a discussion in his special department, by choosing some subject for consideration. As chairman of the obstetrical and gynecological department I have selected for our consideration the subject of "Intra-Uterine Medication." It is not my intention to impose upon you any lengthy paper, nor do I intend to defend, or otherwise, this special subject; but merely to relate my own experience and pronounce my own judgment on this plan of treatment in certain uterine affections and thus draw from those present, interested in the subject, their own ideas and value of the procedure. I am well aware that this plan of treatment has its adherents, but it also has its opponents. There are some excellent men on our own continent who are strongly opposed to the procedure, while again in the old world some men equally good who are just as strongly in favour of this plan of treatment, and while I greatly respect both of these classes of practitioners, yet I unquestionably belong to those who believe in the great advantages of this plan of treatment in properly selected cases. To apply this system of treatment to all and every local uterine complaint is undoubtedly hurtful; to exclude constitutional treatment and depend entirely on local

treatment is also wrong, the two plans of treatment should go hand in hand. That injurious effects have probably arisen in some cases I do not doubt, but at the same time I am disposed to attribute these bad effects to neglect of certain precautions and not to the plan of treatment itself.* The more clearly the subject is understood and the dangers known of the indiscriminate use of this plan of treatment, the greater will be the good results. The conditions most benefited are diseases of local origin, such as we see following abortions or confinement, the condition known as subinvolution, uterine catarrh, diseased conditions of the mucous membrane of the uterus, chronic endometritis, profuse and frequent menstruation, metrorrhagia, a large and flabby and relaxed uterus, cervical hyperplasia, cervical erosions, supersensitive condition of the lining membrane of the uterus, and uterine fungosities; while tumors and polypi and conditions depending on diseases of the Fallopian tubes and ovaries are not thus to be treated. I am quite satisfied that in all these diseases constitutional treatment is of the greatest importance and must not be neglected, but still it alone will not produce a cure; it is necessary to treat the diseased uterus locally.

We come now to consider the mode of applying the remedies. For the successful application of any remedy it is necessary that the cervical canal be sufficiently patulous to allow of the easy passage of a probe, armed with cotton wool, and saturated in the remedy, to pass through into the uterine cavity. In the diseases to which I have just alluded such is generally the condition, but if not it must be dilated first. Secondly, all mucous secretion should first be carefully removed from the uterine cavity so as to enable the remedy to come into direct contact with the diseased surface. And thirdly, no uterine inflammation or tenderness in the surrounding vicinity of the uterus should exist. First remove such tenderness by leeches, scarification, hot vaginal douches and rest in bed, and gly-

* The reason assigned by those who do not approve of applications to the uterine cavity is that the mucous membrane is being constantly removed and renewed, and hence no good will come of applications. Such might also be said of the skin. Take a case of simple chloasma, because the epidermis is being constantly renovated are we not to treat this disease by local applications. So in cases of cystitis, the same thing would be applicable, and I might multiply such instances. To my mind it is not a sufficient argument against Intra-Uterine Medication.

*Read before the Ontario Med. Association, London, June 4th, 1885.

cerine pads, and then proceed to heat the cavity. To apply any remedy to the cavity, I think the best position for the patient is on her side with nates near to edge of the bed, then having introduced a good large sized Sim's speculum into the vagina, the os is fully exposed to view; then lay hold of the anterior lip of cervix with a pair of vulsellum forceps and draw down the parts, pass a sound gently through the canal to ascertain its exact course, cleanse out the cavity with one or more of Playfair's probes wrapped round with cotton wool (absorbent), then take another, previously bent to correspond to the cervical canal, dip it in the solution you are about to use, and pass it directly into the uterine cavity as far as the fundus uteri, turn it round several times so as to touch the whole of the interior and leave it there for a minute or more. Be careful during this part of the treatment that the surplus fluid does not run down the vagina and over the thigh, as it will cause a good deal of pain and discomfort to the patient. Unless nitric acid or some such caustic is being used, it is not necessary to use a cervical speculum or protector, for what fluid is wiped off from the probe in its passage through the cervical canal is only enough to treat this part of the uterus.

Now, as to the frequency of these applications, I think once in four or five days for the alterative and astringents is enough, once in ten to fourteen days enough for the caustic ones. After the application the patient had better, as a precautionary measure, remain quiet for a couple of hours on her bed, though I am constantly in the habit of making such applications in my own office. It is exceedingly uncommon to find any unpleasant symptoms follow such procedure; for my own part I never saw an accident occur. I know it is reported that fatal peritonitis has followed this plan of treatment, and I am inclined to attribute such an unfortunate accident to the fact that the case was badly selected, that some low inflammatory state existed and was not detected, and that the case was not a suitable one. The remedies used are not many; some recommend them in powders, some in ointment, some inject them, while others again apply them by means of a Playfair probe dipped in the desired fluid; this latter is to my mind the best. I do not like the way of injection. I once or twice used that plan but gave it up long ago on account of severe constitutional disturbance. The reme-

dies I most commonly use are carbolic acid (Calvert's No. 5), Churchill's iodine, iodized phenol, iodoform, nitric acid, and nitrate of silver. Undoubtedly many more might be added. The ones I mostly use of this list are carbolic acid and iodized phenol.

Nitric Acid is the strongest of them all, and should only be used for certain diseases; it is especially useful in the treatment of uterine fungosities, that sometimes obstinate disease to treat. Firstly, having dilated the cervix if requisite, and carefully scraped the whole surface of the uterus with the blunt curette, and then carefully wiped out the cavity, pass an armed probe previously dipped in the strong nitric acid through a cervical speculum into the uterine cavity. It is very necessary to use this useful little instrument so as to protect the cervical canal, otherwise sloughing and contraction might ensue subsequently. The vagina should likewise be protected by absorbent cotton dipped in a solution of carbonate of soda, so that if any acid runs out the vagina will not be injured. The application of this remedy to the uterine cavity is not painful nor have I seen any bad results ever follow its use. The patient should be kept quiet for two or three days in bed, and the remedy should not be applied again for ten or fourteen days. In the treatment of these growths I have seen the most excellent results follow; it is in fact, I think, the only condition calling for this strong caustic.

Carbolic Acid—This is a most useful remedy and one which I use largely. I find it especially useful in cases of uterine catarrh, and also in cases of tenderness of the inside of the uterine cavity. I am likewise in the habit of swabbing out the uterine cavity with this remedy after using the curette. Its action is slightly caustic and astringent and alterative. The preparation I am in the habit of using is Calvert's No. 5, simply because it is less caustic than the purer preparations. It causes very little pain, if any.

Iodized Phenol—Until I learned the good effects of this preparation, I invariably used Churchill's tincture of iodine, but of late I have quite abandoned it for this preparation. It was first introduced into practice by Dr. Battey of Georgia, and is made of one part of pure iodine to four parts of carbolic acid. This agent is particularly useful in cases of uterine hemorrhage, profuse menstruation, the result of imperfect involution, accompanied by

an unhealthy state of the lining membrane of the uterus, or in cases of menorrhagia, depending on the presence of vascular growths within the uterus. Dr. Battey likewise recommends it in malignant disease of the uterus, and Dr. Atthill speaks highly in its favor in malignant disease, for the purpose of both arresting the hemorrhage and progress of the disease; he however uses it by injecting $\frac{3i$ of the solution once a week within the uterine cavity, and adds, no unpleasant results are likely to follow it when thus used, providing the cervical canal is patulous enough to allow the surplus fluid to flow back, and that it is injected slowly and not more than one drachm at a time. I have no experience in the use of this remedy in this form.

Iodoform I have used both in powder and crayons, but have not met with such good results from this remedy as to induce me to resort to it frequently.

Nitrate of Silver—I have introduced from five to ten grains of powdered nitrate of silver in cases of dysmenorrhœa, especially the membranous form, but it is painful and sometimes produces unpleasant symptoms, so I have abandoned it for safer and quite as good remedies.

I have thus very briefly brought before your notice this mode of treating uterine disease, and you will gather from the foregoing remarks that while I am a strong advocate for local uterine medication, I do not exclude the great advantages to be derived from general constitutional treatment, nor overlook the fact that uterine displacements, fibroid tumors and allied diseases, must receive appropriate treatment.

I do not intend that this paper should be considered in any other light than as the preliminary remarks to a general discussion on the advisability of Intra-Uterine Medication, and draw from those present an expression of opinion upon this very important subject.

CONTINUED FEVERS.*

BY A. S. FRASER M.D., SARNIA.

The continued fevers, which prevail at times in Western Ontario, are classified as typhoid fever, typho-malarial fever, and malarial continued fever.

In many localities, where continued fevers are

common, cases of typhoid fever which run a normal course are comparatively few in number; much more frequently this disease develops in an irregular and uncertain manner, so much so that often a case of typhoid fever will have lasted for two weeks or more before satisfactory evidence of its nature can be obtained. In consequence of this, many cases of typhoid fever are called typho-malarial fever, although this term is usually applied to cases of continued fever which have many of the characteristics of typhoid fever, yet never show any symptoms of ulceration of the bowels. The name typho-malarial fever has been applied to a form of continued fever which is supposed to be either enteric fever modified by malaria, or malarial fever which has assumed a typhoid or adynamic form from some peculiarity of the patient. There are serious objections to both these views. In the first place, in well marked cases of the so-called typho-malarial fever, there is no reason to believe that ulceration of the bowels is present at any time during the whole course of the disease, as there is no tenderness nor fulness of the abdomen, neither is there any diarrhœa nor rose spots. In other respects the fever takes much the same course as typhoid, lasting from two, to eight or nine weeks; sometimes so severe as to prove fatal early in the third week; at other times showing only a slightly elevated temperature, with little prostration, lasting for four or five weeks, with a gradual return to health at the end of that time. There is seldom much dulness of intellect, and when delirium is present it is of a more active kind than that of typhoid fever.

In the second place, the reasons for believing that this fever is not of malarial origin, are these: 1st. Paludal malaria, which is the only kind of malaria we have to take into account, is developed under pretty well known conditions, and it has always been understood that severe malarial fever is the effect either of large quantities of malaria in the neighborhood of the persons attacked, or of an unusual susceptibility on the part of such persons to the influence of this poison. In either case the source of the malaria would be further from some than others, or some persons would be so much less susceptible to its influence than others, that milder forms of malarial fever, such as intermittent and remittent, would be found in the same locality as the more serious continued fever. 2nd. This

*Read before the Ontario Med. Association, London, June 3rd, 1885.

fever is frequently endemic when the temperature has been below the freezing point for several weeks, and the ground covered with ice and snow during that time, so that if malaria is the cause of the disease, it must have been latent in the persons attacked for some time.

Now it is a well known fact that malaria may remain latent and cause intermittent fever and other forms of malarial poisoning long after the individuals affected have been exposed to its influence; but there is no reason why such latent malaria should cause in a number of people, at about the same time, the most severe continued fever without manifesting any of its milder effects in other persons who have been living under the same conditions.

Most practitioners who have had much experience with continued fevers will agree that the so-called typho-malarial fever is difficult to separate from typhoid fever on the one hand, and malarial fever on the other. That its specific cause is probably similar to and exists under the same conditions as that of typhoid fever. Many will also concur in the opinion that typho-malarial is a term that is both inaccurate and misleading.

The following history will serve to illustrate the danger which may arise from the difficulty in separating malarial from non-malarial fevers. Waterworks were established in the Town of Sarnia in the year 1876. The supply pipe was placed in the River St. Clair, in close proximity to the outlet of a large sewer; but as the pipe extended for some distance into the channel, and the current was strong, it was not considered by those in charge of the work, that the water would be contaminated. It was noticed, however, that typhoid fever was more prevalent during the next two years than at any time before. In the spring of 1879, the supply pipe was broken by an ice jam; no attention was paid to the occurrence, and during the following summer, cases of continued fever became very numerous, many of them fatal. Unfortunately at the beginning of the outbreak the disease got the name of malarial fever. The water supply was, however, also accused of being the source of the trouble, and some samples of water, taken from the river and from hydrants in different parts of the town, were sent to Toronto for analysis. A report came back from Prof. Croft to the effect that the water was remarkably pure. This confirmed in their

opinion, those who believed that the fever was due to malaria. The water pipe was repaired and extended for a distance of a hundred and twenty feet into a channel forty-two feet deep, in which the current ran four miles an hour. The number of cases of fever did not diminish in the least, and there was no doubt that a large proportion of them were uncomplicated cases of enteric fever of a severe type. The water was again analysed more than once and declared perfectly pure. The disease continued for four years, there being constantly present in the town from four or five to forty or fifty cases. Notwithstanding the fact that competent chemists had pronounced the water pure, there were many reasons for believing that it contained the germs of fever, and the town authorities finally decided to close the sewer which emptied near the waterworks, and to direct the sewage to a point some distance further down the river. This was done and the town at once became free from continued fevers, and the disease has very seldom occurred in the place since.

Concerning malarial continued fever, it may be said to have two characteristics which distinguish it from all other forms of continued fever. 1st. It almost invariably yields to sufficient doses of good quinine. 2nd. When a person has once been attacked by this disease he is very liable to subsequent attacks, the reverse being the case in typhoid and typho-malarial fevers.

THE EXTERNAL APPLICATION OF SULPHIDE OF CALCIUM IN SMALLPOX.

BY J. A. M'ARTHUR, M.D., C.M., WINNIPEG, MAN.

Several years ago, Surgeon-Major C. J. Peters, of the British army of India, experimented with sulphide of calcium as an external application in smallpox, and although the cases were few in number, six, I believe, yet such were the favorable results in each and every case, that he was induced to give an account of the treatment adopted. So favorably impressed was I with the success of the treatment, that I resolved to employ it, the first opportunity that occurred.

On the 10th day of April last, I was instructed by the Provincial Government to proceed to the town of Emerson and take charge of a case of smallpox that had recently broken out in that place.

The patient was a young woman, about 23 years of age, and previous to the present attack, was in good health. The form of smallpox was the confluent—the patient never having been vaccinated—and one of the worst cases I had ever seen. The day on which I first saw her was the 9th from the initial stage of fever and 3rd of the pustular stage. The face was terribly swollen and she was unable to see. The conjunctivæ, mucous membrane of the mouth and the tongue were thickly covered with pock. The face, neck, arms and limbs as high up as the knees were literally covered, so much so, that a pin-head could not be put down without touching them, while on the backs of the hands and soles of the feet blebs as large as a half-dollar piece could be seen. There was low muttering delirium, and the symptoms present indicated extreme prostration and a speedy termination of the life of the patient.

Feeling that this was an almost hopeless case and one which would test to the utmost the merits of any remedy, I determined to apply the sulphide and watch the results. The patient's face, neck, arms to the elbows and limbs to the knees were painted twice daily. The application was made with a brush and not with a feather as recommended by Dr. Peters—the work being done much more quickly and thoroughly with the former than the latter. The third day after the application of the remedy and the 12th of the disease, the patient showed signs of improvement. The low muttering delirium passed away, the swollen features assumed their more natural and human character, while the pustules showed signs of shrinking. There was no secondary fever, and at the end of the fifth day from date of application the pustules were literally shrivelled up, without giving out any of their fluid contents. In a word the disease was aborted.

The sulphide is evidently absorbed and acts in a constitutional manner, for the pustules on the parts of the body and arms not painted, shrivelled and dried up equally as rapid as those where the application was made.

Another important feature noticed, was the entire absence of itching and desire on the part of the patient to scratch. At no time did the patient feel any desire in that direction, and the sickly, deathly exhalations, so characteristic, were scarcely perceptible. An examination of the patient's face

last week, revealed no pitting—a very important consideration. The blinds were not drawn nor the room darkened, but a flood of sun-light was permitted to enter the room, and the freest ventilation possible enjoyed. With the exception of slight ulceration of the cornea of the right eye and a slight attack of pleurisy of the right side, the patient made a rapid and successful recovery. The patient was kept on milk diet throughout, and only mild diuretics were employed as occasion required.

The liquid is prepared by boiling a quarter of a pound of quicklime and half a pound of sulphur in five imperial pints of water until the liquid is reduced to three pints, when it is filtered and kept in glass-stoppered bottles. It is applied to the affected parts two or three times a day with a brush or feather, taking care that none of it gets into the eyes.

The writer believes that the lotion acts by destroying the germs of the disease, preventing supuration, and guarding against the complications that result from blood poisoning.

Reports of Societies.

ONTARIO MEDICAL ASSOCIATION.

The fifth annual meeting of the members of the above Association was held in London, on the 3rd and 4th ult., Dr. A. Worthington, of Clinton, President, in the chair, Dr. J. E. White, of Toronto, Secretary. The attendance was large and representative. Drs. Howe and Park, Buffalo, Drs. Jenks and Brodie, Detroit, and Dr. Stewart, Montreal, were present as delegates and invited guests.

After routine, several patients were presented for the consideration of the Association.

Dr. Pope, of Bothwell, showed a case of cerebro-spinal meningitis, in which some paralysis of the right leg, and ankylosis of the hip-joint, had followed. The President also showed a case of neuralgia of the tongue, apparently caused by carious teeth. Dr. Edwards also presented before the Association two interesting cases of myo-sclerosis, occurring in two brothers. All the cases were examined and discussed by the members present.

The President's address was next in order, and was listened to with marked attention. After thanking the Association for the honor conferred upon him, he referred to the opinion held by the

talented Sydenham, who wrote and practised from 1660 to 1680, that the six most fatal diseases prevailing in the city of London, were the plague, ague, dysentery, scurvy, child-birth, and small-pox. He was the first physician who originated the idea and carried the principle into practice, expressed in the phrase *vis medicatrix naturæ*, that this force in nature should be aided, nor thwarted. About the middle of the seventeenth century, or just before the time of Sydenham, the mortality of parturient women in London was about two per cent., including after consequences, while at the time those statistics were taken (1885) it was reduced to one-half per cent., and since the introduction of antiseptics into obstetric practice the mortality rate will probably be diminished to about one-fourth of one per cent. One death in every 400 may be an under-estimate of the mortality from child-birth and after consequences at the present time, but since obstetric practice has been based upon a belief in the germ theory results have been much better. He referred to the probable discoveries in scientific medicine, which they might expect to be greater in future than in the past. Ague was now almost entirely disappearing. Scurvy was likely to be little more than mentioned in the text books of the future; and with reference to the small-pox, of which the learned and accomplished Dr. Mead, the first London physician of the day, wrote in 1747 as impossible to vanquish, vaccination was introduced in 1798, which had successfully battled with the disease. Referring to fever, the President said Boerhaave (1701 to 1731) held a theory of fever peculiarly his own, which was that the blood was the cause, the explanation being that the blood was in a thick, viscid condition, leading him to advise and insist on warm drinks being given during fevers, and that much danger was present if cold drinks were used. He (the speaker) could well remember when a child, some sixty years ago, his aunt begging for a drink of cold water, during an attack of what he presumed was typhoid fever, and was refused, the doctor saying it was dangerous to give it. To Boerhaave then must be ascribed the untold misery of thousands who have died, famished or starved, for cold water. Most unfortunately his theory has been handed down even to the present, and it might be questioned if the idea was yet obliterated from the minds of some of the profession. He then alluded to the use of cold water affusions

in fevers by Currie, and stated that there was no question of their efficacy in scarlatina in every form. He also pointed out the fact that the use of the thermometer under the tongue and in the axilla was introduced half a century ago. In conclusion, he expressed a hope that the brief review of medical science one hundred years ago would be considered worthy of some thought, as indicating the progress which might be looked for in the next century.

There being none of the members of the Special Committee, appointed in 1884, to report on the communication from the Women's Christian Temperance Union, present, Dr. Fulton moved, seconded by Dr. Bray, that a special committee be appointed, consisting of Drs. Holmes, of Chatham; Rosebrugh, Hamilton, Geikie, Toronto; Brouse, Brockville, and the President, to bring in a report on the following morning, which was carried.

A motion expressive of condolence with Dr. Workman, in his recent bereavement, was passed, and a committee appointed to prepare a suitable memorial to be transmitted to him.

The report of the Committee on Ethics was laid over for another year.

A telegram from the Wisconsin Medical Society, in session in Milwaukee, sending greetings, was received with applause, and the Secretary was instructed to telegraph a reply expressing similar well-wishes. Dr. J. L. Bray, of Chatham, read a short paper on "Cæsarian Section," giving the history of a case in which Dr. Jenks, of Detroit, assisted him; the woman died. Dr. Jenks gave a graphic description of the operation, and stating in conclusion that he was opposed to craniotomy.

An interesting discussion on medicine was opened by Dr. Tye, of Chatham, who read an able paper on "Diphtheria." The paper and discussion will appear in the LANCET in due course, so that we shall not attempt to give any epitome.

Dr. Fraser, of Sarnia, next read a very interesting paper on "Continued Fevers."

In the evening session the Secretary read a communication from Dr. McLean, of Detroit, wishing the Society every success, and inviting the members to Port Huron at the annual session of the state medical association. The Secretary was requested to write, thanking Dr. McLean for his kind invitation.

The discussion in surgery was then opened by

Dr. Powell, of Edgar, who read an admirable paper on "Plaster Splints." The paper was discussed by the Association, after which followed an excellent paper on the "Blindness of Pregnancy," by Dr. Howe, of Buffalo, illustrated by diagrams thrown upon a screen. After a paper on "Placenta Prævia," by Dr. Edwards, of London, and another by Dr. Groves, of Fergus, on "Renal Calculi," the meeting adjourned.

On the second day, Dr. Temple, of Toronto, Chairman of the Committee on Obstetrics, opened a discussion upon "Intra-uterine Medication." Dr. Roswell Park, of Buffalo, followed with a volunteer paper on the "Surgical Sequelæ of Fevers. Many cases illustrating the various lesions coming under this head were placed for the first time on record. An important paper, written by Dr. Keen, of Philadelphia, was referred to, and much additional light thrown on a subject worthy of close observation.

At this stage it was found necessary to divide into sections in order to get the papers all before the Association. Dr. Graham, of Toronto, presided over that on Medicine, and Dr. Aikins, of the same city, over that on Surgery and Obstetrics.

Dr. Henderson, of Kingston, led off in the first section with a paper upon "Pulmonary Cavities." Drs. McDonald and Graham of Toronto, took part in the discussion, and the general opinion expressed was in the direction of sustaining the contentions of Koch, regarding the connection between bacilli and phthisis.

Dr. Duncan, of Thamesville, on "Warburg's Tincture," Dr. Ovens, of Arkona, on "Trifacial Neuralgia," and Dr. Arnott, of London, on "Diet in Disease," closed the work in this section by papers worthy of attention. A paper was also read on "Mitral Stenosis" during the afternoon by the Chairman, Dr. J. E. Graham, of Toronto.

In the Surgical and Obstetrical Section, papers were presented on "Hemorrhage after Abortion," by Dr. Murray, of Thorndale, and on "The Treatment of Abortion," by Dr. Adam Wright, of Toronto; one of characteristic vigor and originality by Dr. Harrison, of Selkirk, and one upon "Intestinal Obstruction" by Dr. Atherton, of Toronto.

Dr. Yeomans, of Mount Forest, was down for a paper on "Compound Fracture of the Patella," but unfortunately had to leave by an early train. Finally, the discussion on "Cocaine Hydrochlorate" was opened by Dr. Reeves, of Toronto, and taken

part in by Drs. Howe, of Buffalo, and Palmer, of Toronto.

The Special Committee appointed to answer the questions submitted to the Association by the Ontario W. C. T. U. presented the following report, which was adopted:

Is the beverage use of alcoholic liquors, by persons in health, beneficial? A.—No.

Is alcoholic liquor, as obtained in common sale, necessary in medical prescriptions, if so, in what cases particularly? A.—No, except in cases of emergency.

What ought to be the attitude of the medical profession towards the sale of intoxicants? A.—The medical profession is opposed to the indiscriminate sale of alcoholic liquors.

The officers elected for next year, when the Association will meet in Toronto, were: Dr. Tye, President; Drs. Arnott, Temple, Hillary, and Henderson, Vice-Presidents; Dr. White, Secretary; Dr. Graham, Treasurer; Drs. Wright, Campbell, Ayelsworth, and Mitchell, Corresponding Secretaries.

ONTARIO MEDICAL COUNCIL.

The annual meeting of the Ontario Medical Council was held in Toronto on the 9th ult. and following days. The following newly elected members answered to their names:—Drs. D. Bergin, Cornwall; J. L. Bray, Chatham; H. E. Buchan, Toronto; J. H. Burns, Toronto; C. T. Campbell, London; J. G. Cranston, Arnprior; H. W. Day, Trenton; R. Douglas, Port Elgin; E. G. Edwards, London; A. G. Fenwick, London; F. Fowler, Kingston; W. B. Geikie, Toronto; W. T. Harris, Brantford; G. Henderson, Strathroy; G. E. Husband, Hamilton; G. Logan, Ottawa; V. H. Moore, Brockville; Orr, Maple; Philip, Brantford; J. W. Rosebrugh, Hamilton; Russell, Binbrook; Ruttan, Napanee; E. Vernon, Hamilton; J. A. Williams, Ingersoll, H. H. Wright, Toronto, and J. A. Grant, Ottawa.

Dr. Bergin was elected President, and Dr. Douglas Vice-President of the College. Dr. W. T. Aikins was appointed Treasurer, and Dr. Pyne re-appointed Registrar.

The standing committees were appointed as follows:—

Registration—Drs. Rosebrugh, Vernon, Fenwick, and Russell.

Rules and Regulations—Drs. Day, Burns, Fowler, and Williams.

Finance—Drs. Edwards, Henderson, Douglas, Philip and Ruttan.

Printing—Drs. Vernon, Burns, Buchan, and H. H. Wright.

Education—Drs. Fowler, Geikie, Moore, H. H. Wright, Edwards, Harris, Day, Husband, Logan, Williams, Burns, Cranston, Bray, Fenwick and Buchan.

Executive—Drs. Day, and Logan.

The report of the Building Committee stated that there was a suitable site for a new college south of the School of Practical Science on College-street, and recommended that a committee be appointed to secure the site. The site which belongs to the Toronto University, can be obtained, on payment of \$500 interest on it annually to the University. The matter was referred to the Finance Committee.

June 10th 1885.

The Council met at 10 a.m.

Dr. Wright moved that all medical students engaged in the North-West, be allowed their full time, but they shall be required to take their primary examination next spring, or at the final examination.

Dr. Geikie moved in amendment, seconded by Dr. Moore, "That those primary students who had been prevented from undergoing the spring examinations by their service in the North-West, and who had paid their fees, be given their standing."

Dr. Wright argued that the Act gave no power to dispense with the examination, and the President on being appealed to for his ruling, suggested that both resolutions be withdrawn till the advice of the solicitor be obtained.

Dr. Day presented the report of the Legislative Committee. It stated that the Committee had been unable to obtain from the Legislature the amendments to the Medical Act, which were deemed so necessary, but had hopes of obtaining legislation next session. They therefore recommended the re-appointment of the Committee.

An application was received from Dr. E. B. Sparham, of Brockville, asking that his name be reinstated in the list of those licensed by the college to practice.

June 11th, 1885.

The Council met at 10.30 a.m.,

Dr. Fenwick moved that the Council examinations be held in London, as well as Toronto and Kingston. The matter was referred to the Committee on Rules and Regulations.

Dr. Cranston moved that the President, or in his absence, one of the officers of the college, shall have power to appoint in each territorial division, on the recommendation of the representative for such division, one or more persons whose duty it shall be to prosecute persons practising in contravention of the Medical Act, and that the prosecutor receive 75 per cent. of the fines inflicted. Carried.

A by-law was then passed fixing the annual assessment at \$1 per annum.

A by-law was also introduced by Dr. Williams, and passed, fixing the date of the professional examinations on the first Tuesday in April in each year.

Dr. Campbell moved that a copy of the proceedings of Council be printed and forwarded to each member of the college.

Dr. Wright moved in amendment that a synopsis of the proceedings be printed in the annual announcement, and a copy sent to every member in good standing. The amendment was carried.

Mr. Dalton McCarthy, Q.C., the solicitor of the Council, gave as his opinion that there was nothing in the Medical Act to prevent the Council from giving students in the North-West their primary examinations. Dr. Geikie then introduced a by-law to the effect that the students be allowed their primary examinations, which was carried.

The following were appointed members of the Legislative Committee: Drs. Day, Cranston, Edwards, Fowler, Williams, Husband, Douglas, Logan, Moore, Wright, Geikie, and Harris.

The members of the Council were entertained at lunch, in the evening, by Dr. Aikins, Jarvis St., in which they were joined by members of the profession in Toronto, and a pleasant time was spent.

June 12th, 1885.

The Council met at 10 a.m., the Vice-President in the chair.

Dr. Bray moved that the Legislative Committee be authorized to approach the Legislature next session with the object of obtaining the desired amendments to the Medical Act.

On the report of the committee appointed to recommend a solicitor for the council, Mr. B. B. Osler received the appointment.

The Registration Committee reported in favour of allowing F. B. McCormick, South Point, Pelee Island, to come up for registration. They also reported that the Council had no power to re-enter the name of E. B. Sparham on the register.

The opinion having been expressed by the solicitor that the University of Ottawa had no power to confer degrees in medicine, and therefore no right to representation in the Council, a reply was received from the authorities of that institution stating that they had the power to grant degrees in medicine. Dr. Grant, of Ottawa, who was present, was accordingly invited to take his seat as representative of the Ottawa University, and accepted the invitation amid great applause.

Dr. Cranston moved that a vote of thanks be passed to the Ontario Government for their exertions in perfecting the Bureau of Health. Carried.

Dr. Wright presented the report of the Education Committee, which was adopted. It recommended a change in the regulation requiring graduates of arts to spend four years in college, to three years as formerly; also that students passing the matriculation examination, shall prove their identity. It also recommended the increase of the registration fee to \$25, and the re-appointment of the examining board of last year.

Dr. Day presented the report of the Committee on Rules and Regulations. It stated that the solicitor had reported that the Council had no power to hold its final examination except at Toronto and Kingston, but that primary examinations could be held wherever the Council chose.

Dr. Henderson presented the report of the Finance Committee, which was adopted. It stated that there was a balance on hand of \$6,291.53, after all expenses had been met. The total assets, including cash on hand, building and grounds, and dues uncollected, are \$33,291.51, and total liabilities embracing the mortgage and interest, expenses of the present Council, and unpaid accounts, \$8,318.39. There is a balance in favor of the Council of \$24,973.14. The arrears of members' fees amounted to \$7,000.

Dr. Grant moved that Drs. Burns, Wright, and the Secretary, be a committee to adopt some inexpensive way of protecting the papers and documents of the Council. Carried.

Dr. Harris moved that this Council record with pleasure its sense of the zeal displayed by those medical students who have served in the North-West. Carried.

After the passing of formal votes of thanks the Council adjourned *sine die*.

Selected Articles.

DISSEMINATED CEREBRO-SPINAL SCLEROSIS.

BY DYCE DUCKWORTH, M.D., F.R.C.P.

St. Bartholomew's Hospital.

GENTLEMEN,—I bring before you to-day a patient lately admitted to Bed 1, in John ward, whose case furnishes me with some points of great interest, to which I shall ask your attention. It is one of a class well fitted for a clinical lecture, which, as you know, is nothing if not demonstrative, and little more than a systematic or didactic one if the patient is not brought before you. Clinical medicine has all to do with individual cases, and that teaching of it is most proper which best illustrates the points to be noted to each of you in as direct and living a manner as possible.

I will presently tell this man to walk across the theatre, and ask you to notice his gait. If you look at him first as he stands at rest, you will not observe anything remarkable about him. You see a young man in seeming good health, well nourished, and with complete control over his equilibrium. I now ask him to close his eyes. He stands erect, and without any tremor or instability. And now, as he walks, you notice a peculiarity in the action of his right leg. This limb moves stiffly, and there is over-action of it. It is lifted higher off the ground than the other, and is clumsy in movement. We say there is some spastic action in it. I now give him this glass of water to take in his right hand. At once, you see, a violent spasmodic action occurs, vigorous tremulation, so great that he nearly empties all the water before he has well seized the glass. If he next attempts to raise the vessel to his lips, the movements become more and more exaggerated, so that all the water is spilt and the empty glass rattles against his teeth. I remove the vessel from his hand, and all the spasm ceases forthwith. As he stands quietly once more, you notice that the right arm remains tranquil and free from tremor. I try his power of grasp in each hand, and find a marked weakness in the right one, although he is a right-handed man. I now lay bare his forearms and compare the condition of his muscles. You observe no signs of wasting; the muscles are well developed and of good and equal tone on both sides. On examining his face, you see that his muscles of expression are stable and free from tremor, his lips firm, and his eye-balls quite steady. His pupils are unequal, certainly, but that is due to the action of atropine in one of them, used to allow examination of the retina of the right eye. No squint; no facial palsy. Testing his sensory functions, we find no abnormal state; all is as it should be. On enquiry as to any

subjective sensorial sensation, he assures us all is natural in each of the four extremities. To curtail our further examination, I may add that there is nothing more to be detected by any physical methods we can employ, save that the knee-reflexes are exaggerated, markedly on the right side, while no ankle-clonus can be elicited. We have, then, a seemingly healthy and vigorous young man, whose only troubles are a clumsy limping gait, due to disorderly action of his right leg, and inability to employ his right hand and arm because of powerful tremulation and disorderly spasm, which come on the instant he directs his will into this extremity; and this is all. Before he leaves the theatre I ask him to repeat a sentence after me. You notice that he speaks clearly and fluently—with a good Wiltshire accent to be sure, but without any hesitation or difficulty; and yet, again, on protruding his tongue, you find no noteworthy tremor or peculiarity in it. Let us now take up the history of this case; it is very brief.

G. R.—, aged twenty-one, a groom, was sent up to us by a former pupil of the hospital, and admitted on Feb. 14. He states that nine months ago trembling movements began in his right arm, which prevented him from following his occupation.

Later on the right leg became affected, so that he could not walk far on account of the weakness in it. Inquiry into his past history revealed no important illness. He had never had rheumatism, and there was no known history of this or of gout in his family. He had never had chorea, although his present ailment was at first believed to be of this nature. There was no neurotic history in his family, no indication of any previous paralytic attack or hemiplegia, no injury of any kind, and no history of fits. His duties entailed exposure to all kinds of weather, but to no extraordinary exposure. Previous to admission, he had been treated, we learned, with arsenic, belladonna, mineral water bathing at Bath, &c., all without avail.

You have already noted that the patient appears a healthy and well-nourished man, and that so long as he makes no voluntary efforts with the limbs of the right side of his body there is no indication of disease about him. I show you a specimen of his attempt to write his name. After violent efforts to control the right hand he made this unintelligible series of scrawls. With the left hand he has learned to write fairly legibly, but slowly and with difficulty, still without any spasm or tremor. He is awkward in setting his right forefinger on any point; thus he makes bad shots at his nose when he tries to touch the end of it, and hardly succeeds in getting near it. Dr. Stevenson has given us a report on the electrical reactions of the muscles of the affected limbs, and he states that they all react normally to both continuous and interrupted currents, and that there is no loss of electro-sensibility. We have seen the exaggerated reflexes at the knees,

especially on the affected side; and you may note an increase in the supinator-reflex of the right arm. No fibrillary muscular contractions. On examining the thorax, nothing abnormal is found. The heart-sounds are healthy and sufficiently loud. The urine is natural and the sphincters act perfectly. Special senses not perverted. No vertigo. Knows where his feet and hands are. Retinæ perfectly healthy, and optic discs well-defined. No nystagmus; pupils react naturally; no strabismus. No history of syphilis, and no signs of either inherited or acquired disease of this character. No tenderness on percussing the cranium at any point. In trying to follow with his right toes a circle drawn on the floor is he very clumsy and erratic. He can jump, though with exertion of more force than is necessary for the distance traversed. The difficulty with the right leg is best seen when he tries to run.

We find, on the whole, more negative than positive signs in this man, and yet we have very definite symptoms before us. What is the lesion here, and where is it? What is the diagnosis and what the prognosis, and the best treatment of it? I mentioned that chorea had been at first suspected in the case. Chorea is sometimes one-sided, and often so, for a time in many instances. You would not or you should not long be mistaken as to this. You know that choreic movements are incessant except during sleep, and not only elicited by effort, although they are aggravated by voluntary efforts. And you would not expect to meet with a case of one-sided chorea lasting continuously for nine months. We may, therefore, put that aside. You think, perhaps, of another nervous disorder characterized by tremors and paralysis agitans; the shaking palsy (Parkinson's disease) suggests itself to you. Is this the malady before us? Here is Parkinson's own definition, written in 1817: observe if it tallies with our case: "Involuntary tremulous motion with lessened muscular power in parts not in action, and even when supported; with a propensity to bend the trunk forwards and to pass from a walking to a running pace, the senses and intellect being uninjured." This definition will not apply here. The rule is for the tremor to be persistent and constant in shaking palsy, and rather to cease or moderate when action is induced. The contrary is the case here. Action at once induces tremor. The age of this patient is against his being the subject of shaking palsy, this disorder being very rare before forty years of age are reached. Have we here to deal with a case of so-called post-hemiplegic chorea? I think not, because we have no history and no signs of a past attack of hemiplegia, and the characters of this man's tremors are not those of the disorder I have alluded to. To mention mercurial tremors is sufficient. These are symmetrical, and affect the head, and the signs of mercurialism are always obvious. We can also exclude hysterical tremors and malingering.

We are brought, at last, to consider this case, then, as one of a class known as insular or disseminated cerebro-spinal sclerosis, or Charcot's disease, as it has been called. It is a remarkable example, certainly, because the disorder is, at present—note, I say, *at present*—*hemiplegic in character, and also manifestly in an early stage*. We do not often see such cases. This is our diagnosis: sclerotic patches situated in the left half of the brain, possibly in the corpus striatum or crus, and possibly in some portion of the medulla spinalis. I should not like to pronounce with greater certainty anything more than this at present, though I might exclude the inferior frontal convolution and parts around the fissure of Sylvius, with some other regions. We may exclude scrofulous and syphilitic disease in the case, and we are in face of the characteristic lesions which are usually found in these cases, and for which I refer you to your studies in morbid histology. The age of our patient is just that at which this malady declares itself. It is equally common in each sex, and very rare after forty. Exposure to cold has been a commonly assigned cause. In this disease no muscular *wasting* occurs, although loss of muscular *power* is found, and no electrical changes arise. Paresis precedes the tremors, and the reverse is the case in shaking palsy. The reflexes are exaggerated. I should not omit to point out to you that many symptoms are wanting in this patient to complete the picture of a typical case. Such a one we had fifteen months ago in John ward. For example, one looks for nystagmus, and for certain symptoms referable to disorder in the medulla oblongata in most of these cases. I never met before with the exact conditions you see in this man; but, still, I have hardly any hesitation in making my diagnosis.

As to prognosis. This is certainly grave. I surmise that we have so far only early symptoms before us, and that the disease will make sad progress in time. We may fear the onset of paresis and tremors in the sound limbs, and the implication of speech with what are termed bulbar symptoms. The sclerotic process may spread and new patches of it occur in other portions of the cerebro-spinal system, thus setting up new symptoms. The course of the malady is slow, and may occupy from five to ten years. Deceptive periods of improvement may occur from time to time. Too often the disease goes on from bad to worse till the patient is rendered helpless and bedridden, the limbs becoming rigid and paralytic dementia supervening. Can we do nothing to arrest this terrible process? Must it go on to the bitter end? Alas, the resources of our art are, we must honestly avow, powerless as yet to avert the progress of this terrible malady. Physicians have been very assiduous in elaborating the differential diagnosis of nervous diseases of late years, but in respect to therapeutics we have as yet scored few triumphs. The outlook

is bad, and we might almost despair of rendering help. We shall never do this, I hope, but rather strive the harder to find means of arresting this untoward process. No one drug is pre-eminently indicated. I am giving this man mercury, and mean to bring him fully under its influence. He takes three grains of blue pill each night. Not that I am trying to eradicate any syphilitic taint, for, in truth, we know of none in this case. But we know that mercury is a powerful drug, and able to modify nutritional force very materially. We shall do our patient no harm with it. It may be that some of these obscure perversions of growth are evolutionary forms of syphilis transmitted from infected ancestry, and so mercury, fully tried, may chance to be of special use. We know, at any rate, that in the peculiar form of systematic sclerosis of the posterior spinal columns known as the *tabes dorsalis*—*locomotor ataxia*—syphilis plays a very prominent part, to the extent, indeed, of eighty per cent., or more, of all cases. Not that the lesion is itself directly syphilitic or gummatous, but that syphilis, as syphilis, seems to predispose to the particular form of sclerotic change in the cord which sets up the disease we know as *tabes dorsalis*. We are also maintaining the nutrition of this man's nervous system by cod-liver oil and a good diet. Nitrate of silver has been found of use in early stages of this disease. But for some time to come I should prefer to use mercury and iodide of potassium and carefully watch their effects, and I shall bring the results and the further history of this remarkable case before you on a subsequent occasion.—*Lancet*.

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THE "HAMMOCK" MODE OF APPLYING THE PLASTER JACKET.

Dr. A. B. Hirsh, of Philadelphia, gives the following, in the *Med. & Surg. Reporter*:

What physician who has ever treated spinal deformities has not lost temper when using ordinary *suspension* to apply the plaster jacket, when the patient has almost been strangled by a sudden slipping of the straps sustaining the head, or has fainted or become utterly unmanageable? Then, too, there is the discomfort to the patient of keeping up a constant muscular strain, in a peculiar position, for a more or less lengthened period; while if (as usual) he or she be young in years, the fear or even fright of the patient adds to the unpleasantness of the whole affair. Of course, the expense of the necessary tripod and accompanying apparatus is also not the least item to the practitioner.

These thoughts were suggested by seeing Professor Nancrede recently apply a plaster jacket at St. Christopher's Hospital, before his polyclinic class. No originality is, I believe, claimed—an English surgeon first having suggested the ham

mock for this purpose. In this case, a poorly-nourished Irish lad, aged some eight years, had the corset applied for a posterior dorso-lumbar curvature, although the doctor explained that any and every variety of spinal deformity could be treated by a modification of the same method.

A piece of ordinary "ten-ounce burlap"—the bagging used to wrap around rolls of carpet, etc.—some seven feet in length and three feet in width, was suspended between the two sides of the room. Each end of the canvas has a "casing" about one and one-half inches wide, strongly sewn, and a rope drawn through the space thus made (so as to "bunch" the end), which is then attached to a heavy hook or ring screwed into the wall, with a compound pulley and rope to render taut the swing; here we have the convenient hammock as required.

The lad, devoid of clothes, except a woollen undervest, was next placed therein, face downwards and with hands and feet extended—the former grasping the sides of the hammock, so as to exercise some extension—and a hole was cut through the bottom of the swing opposite to the nose and mouth, so as to allow him to breathe easily. Care was taken to fit the usual abdominal pad, and to keep the hammock well balanced. The hammock was then cut transversely on a level and down to the iliac crests; the same was done at the upper margins of each axilla. The flaps thus formed were folded around the body, the surplus portion removed, and the whole roughly sewn up, thus forming a second undervest around the woollen one. Starting from above, the bandage was now carried around the body until the deformity was completely covered, the canvas being, of course, included in the turns. The plaster was allowed to set, and the patient relieved from his swing by cutting loose the burlap above and below the jacket, and the procedure was complete. At no time was discomfort complained of, as the little one even joked about the novelty of his situation.

The professor proceeded to explain that this hammock achieved all the good that Sayre's swing did, and obviated all its objectionable features. On the latter, the curves above and below the gibbosity were straightened out, as well as any lateral deviation, and thus the apparent increase in height was obtained, while the weight of the body, by a true process of leverage, effected through the over curved portions of the spine, above and below, theoretically tended to separate the softened and diseased anterior surfaces of the vertebral bodies. Whether this latter result was desirable, if obtainable to a marked degree, was more than doubtful in the lecturer's mind, as he thought all that should be aimed at was to remove the weight of the trunk, head, and upper extremities—one or all, according to the portion of the diseased vertebræ—and to place the column in the best position attainable, for ankylosis and future usefulness. In the same way, the prone

position in the hammock effaced the curves, and, by leverage, tended to separate the anterior surfaces of the vertebral bodies. The degree to which the hammock was allowed to "sag" would determine the amount of extension exerted upon the spine.

This method was cheap, comfortable and always available, without any special apparatus, beyond bagging, ropes, and strong screw hooks, staples, or some similar contrivance. The patient might be allowed to swing for hours, until the plaster was perfectly dry, thus obviating the risk of cracking the jacket, which sometimes happens when the patient is perforce, taken down too soon from Sayre's swing, on account of fainting, etc., as the professor had experienced in his own practice. The screaming, struggling, and terror, so common with children, is all done away with. It is the part of wisdom to place a mattress on the floor beneath the hammock, lest any part of the apparatus break, and a serious fall result. The professor now always resorted to this method of applying the jacket, and was perfectly satisfied with it.

INTERNAL SPINA-BIFIDA.

Dr. Thomas was consulted by a married lady, aged twenty-eight, two years married, but sterile. She complained of nothing but pain in sacral region, and sense of weight. On examination he found a sac filled with fluid, occupying the cavity of the sacrum, and pushing the rectum aside slightly, but in no way occasioning serious inconvenience. He believed the failure to conceive was due, not to the pressure of this tumor, but to a congenital sharp anteflexion, and advised non-interference. The case stumped the doctor—he didn't know what to make of it—though he examined the case repeatedly, at intervals, for two years, when he lost sight of it. Some time afterwards he was consulted by a beautiful girl, nineteen years of age, who appeared to be perfectly healthy, but who suffered from dysmenorrhœa. She was engaged to be married, and she and her mother were anxious to have any impediment removed that might be in the way, and hence the consultation. Dr. Thomas found a sac filled with fluid, situated in the curvature of the sacrum, and impinging on the vaginal canal to such extent as to almost completely occlude it, and this, the doctor thought, was the cause of her dysmenorrhœa. He strongly advised non-interference, stating that in view of the obscurity of the case radical measures were not justified. Mother and daughter insisted, and finally the doctor consented to a compromise—he would aspirate the sac. He did so with the smallest-sized Dieulafoy's needle, drawing off eight ounces of perfectly limpid non-albuminous fluid, which was submitted to Dr. Garrigues for examination. Dr. G. declined to

give an opinion of the nature or source of the fluid. The effects of this operation were alarming; the girl was thrown into violent fever with headache, which lasted several days. This was attributed to the "thief in the community," malaria, and treated with quinine and morphia hypodermically. Some six months afterwards, the patient and her mother called again: the sac had refilled, and they renewed their importunities for an operation. Dr. Thomas was strongly impressed with the impropriety of any operation, especially in view of what had just been related, and was possessed, he says, of a strange feeling of dread and fear. However, he yielded. He would open the sac, and establish drainage. With proper assistance, patient in lithotomy position and anæsthetized, Dr. Thomas made an incision into the sac and stitched the edges to the vaginal opening. There was discharged about half a pint of the same clear fluid, resembling hysterical urine. In five hours, at 8 p.m., she was seen by Dr. Dubois, one of the assistants; severe headache and marked tendency to hysteria. In the morning, headache more severe, pulse 110, temperature 102. In the evening, symptoms same, with a peculiarly wild and maniacal expression. Still the doctor did not suspect the real nature of the case. Next morning all symptoms were favorable, but in the afternoon the physician was summoned in haste to see her. Found her in a condition bordering on hysterical mania, with pulse 120, and temperature 104, with strong tendency to opisthotonos, and showing marked signs of incipient tetanus. "Now," says the doctor, "there suddenly flashed across my mind the full recognition of the case; an exactly similar one, which had occurred to Dr. Emmet in the Women's Hospital, came back to my memory, from which, until now, it had been entirely effaced; and, as if a curtain had been lifted, I saw clearly what had, until this moment, been so obscure. I had opened a sac formed by the meninges of the cord, which had projected through an imperfection in the sacrum, into the pelvic cavity. The membranes of brain and cord were deprived of the rachidian fluid, and the consequences were before me! I at once collected my assistants, and anæsthetized the patient with chloroform, and sewed up the opening in the sac. * * * Whether from chloroform narcosis or not I cannot say, but for some hours after this, the patient markedly improved, and I had great hopes that I had retraced my unfortunate steps in time; but about twelve hours after the closure of the sac the heart suddenly failed, opisthotonos occurred, the patient shrieked from severity of her cephalalgia—and died!"

In the conclusion of this most interesting record, Dr. Thomas says:

"Where a cyst is found in the pelvis, behind the rectum, filling the hollow of the sacrum, appar-

ently attached to that bone, let the diagnostician carefully exclude the possibility of its being spina-bifida before interfering with it."

2. "If it be decided to interfere with such a tumor, let a small portion of the fluid be first drawn by a hypodermic needle, and if this be found to be a limpid, non-albuminous fluid, let the probabilities of the sac being connected with the meninges of the cord receive due consideration, and guard against further interference.—*Am. Med. Digest.*

HYSTERECTOMY FOR UTERINE FIBROIDS.

Dr. W. T. Lusk presented a large fibroid tumor (*N. Y. Obstet. Society*), together with a number of smaller ones, which had been removed, with the uterus, from a patient who gave the following history: She was thirty-eight years of age, and entered the hospital in March last, suffering from ascites and some form of abdominal tumor. The ascites was so great that it was impossible to determine the exact nature of the tumor. The patient was greatly reduced in flesh and in general health, and was passing only from one to five ounces of urine daily. It seemed hardly possible that she could live more than a few weeks. Dr. Lusk removed a portion of the ascitic fluid, after which he was able to make out what he supposed to be a large fibroid of the uterus, although he was in some doubt whether the case might not be one of abdominal pregnancy. After the patient had been under observation for some time he became convinced that it was one of multiple fibroids of the uterus, there being one large tumor and a number of smaller ones attached by pedicles. Mr. Tait, who had been asked to examine the patient, had summarily rejected the idea of uterine fibroma, and, when asked what he thought the condition was, had characteristically replied, "Cut the patient open and find out." Several other gentlemen, however, who saw the patient a day or two later, coincided in Dr. Lusk's diagnosis. Dr. Lusk was surprised, on returning from the country after the summer, to learn that the patient was still alive, and had even improved somewhat in condition. The house physician had been giving her acetate of potassium and digitalis, and so long as these medicines were continued the urine was secreted in normal quantity, but as soon as they were withdrawn it decreased in amount and her condition grew worse. Her desire to go home was acceded to soon after Dr. Lusk's return to the city, but she had scarcely been absent twenty-four hours when the dropsy largely increased in amount, and she returned and was again given acetate of potassium and digitalis, with the effect of increasing the urinary secretion. The urine contained albumen. It was evident that the patient could not live much

longer without interference, and yet the kidney complication and ascites made recovery after an operation extremely doubtful. It was decided, however, to make an abdominal section, Dr. Lusk's idea being that if only a single fibroid was removed it would tend to make the patient relatively comfortable. The operation was performed about seven weeks ago. When the peritonæum was opened, about a gallon of ascitic fluid escaped. It was the operator's intention to remove the fibroids one after another, but they proved to be very numerous, and, accordingly, he turned out the entire mass, threw a powerful, large-sized rubber cord around its pedicle and cut it away.

The only point to which he wished to call special attention regarding the operation was the fact that, after the method of most operators in such cases, he introduced the needle, intended to fasten the pedicle to the abdominal walls, through the stump below the ligature. This he now regarded as a mistake, and, on account of the distress which it caused the patient, he withdrew the needle on the third day and passed it through the stump above the ligature, which afforded some relief. The day following the removal of the needle some febrile disturbance developed, which was found, on lifting the stump with a tenaculum, to be due to a collection of about a teaspoonful of pus in the upper portion of the wound. The next day the temperature rose again, and it was then found that there was some pus in the lower portion of the wound. As soon as this foetid pus was washed away the temperature fell, and convalescence was thenceforward uninterrupted. There was no further kidney trouble after the operation; the urine was secreted in normal quantity, and no longer contained albumen. This fact was worthy of note, because it was stated in works on obstetrics that inefficient action of the kidneys in puerperal eclampsia was not due to pressure of the gravid uterus, otherwise a like trouble would arise from pressure of ovarian and fibroid tumors. Here was a case in which pressure was made by a tumor, and removal of this caused albumen to disappear from the urine immediately, and the fluid to become secreted in normal quantity. In reply to a question, Dr. Lusk said the entire uterus was removed with the tumor, which weighed seven pounds and a half; the stump separated on the twelfth day. He had had the valuable assistance of the president during the operation.

The President asked Dr. Lusk, who had spoken of tympanites (which was present in this case) as being the rule, if this was true of all cases of extirpation of the uterus, whether the stump was treated extra-peritoneally or not. Dr. Lusk said he meant to refer only to those cases in which, the stump being short, the pressure of the needle was very near the descending colon.

Dr. J. B. Hunter remarked, with regard to the effect upon the kidney of removal of the tumor,

that recently, in two cases operated upon by two different surgeons in this city, the urine, which had been apparently normal, became completely suppressed about the seventh day after the operation, and the patients died. The cases had progressed favorably until suppression of the urine had taken place. Dr. Hunter also remarked that he had employed the rubber cord, shown by Dr. Lusk, with satisfaction.

The President had reported a case last spring in which he hesitated to operate for the removal of a fibroid tumor, because the urine contained albumen, but, instead of suppression of urine after the operation, as had been feared, the albumen disappeared and the secretion became normal, showing clearly that albuminuria had been due to pressure of the tumor upon the kidneys or upon the ureters.—*N. Y. Med. Journal.*

MOTOR APHASIA FROM INJURY, WITHOUT PARALYSIS OF ANY OF THE LIMBS.

Dr. J. H. Burns reported the following case to the Toronto Medical Society (*Med. News*). Mr. K., æt. 56, healthy and robust, fell down stairs; he was assisted to his feet and with help walked to a chair. He did not then speak or at any time subsequently. He became unconscious about three hours later. In my absence Dr. Duncan saw him that evening for me, and with me the next morning, by which time he had recovered consciousness and was able to leave the bed. His bowels had been freely moved with croton oil. There was an injury to the soft tissues over the right eye, but no fracture could be made out. He swallowed with great difficulty; there was neither motor paralysis nor anæsthesia of any part of the limbs. Twenty-four hours after injury pulse was 100, temp. 101°. Dr. Workman saw him in consultation following morning; temp. 104°, pulse 120. During the afternoon he had a convulsion and after that convulsions recurred every ten minutes till he died at 2 p.m. next day. The left side was most affected with the convulsions. During this time there was retention of urine. Death took place sixty-eight hours after injury.

Post-mortem seven hours after death. Extravasation into subcutaneous tissue over parietal and temporal bones of right side. There was an extensive fracture in this region, with slight depression. Dura mater intimately adherent to calvarium. A large clot was found between dura mater and skull at seat of fracture. Great congestion of cerebrum beneath this. Another clot was found beneath the dura mater on left side of brain opposite seat of injury, with extensive disorganization of the lower part of middle lobe of brain on left side. Heart

and lungs normal, liver small but apparently healthy, kidneys healthy.

Dr. Duncan, who assisted at the autopsy, said there were two distinct clots on the left side; one in the arachnoid space pressing on the temporo-sphenoidal lobe, another beneath this in the brain substance, in which on removal of the clot there was a laceration half an inch deep and one and one-half by one and one-fourth inches in extent. This clot probably resulted from rupture of a branch of the Sylvian artery. From symptoms, he had expected to find some such injury. The presence of *three* distinct clots was an unusual circumstance.

Dr. Workman said that he visited the patient in consultation on the 13th of April, and he is able to confirm all that has been stated. The symptoms that most attracted his attention was that of motor-aphasia unaccompanied by any paralysis in the lower or upper limbs. The only mark of external injury was the swollen and blackened state of the right eye. Close examination of the supra-orbital region of the frontal bone gave no indication of fracture, nor did examination of the side of the cranium present any. The patient had evidently free use of the muscles of the arms and legs. When he saw him there was no stertorous breathing, neither was pronounced coma present, but there was a certain degree of torpor or somnolence, which he apprehended would culminate in coma. He had not spoken from the time of occurrence of the injury, neither had he taken any drink or food, most probably because of the paralyzed state of the glosso labial muscles. The large extravasation of blood in the left temporal region, the result of the *contre-coup*, showed that some important vessel, most probably a branch of the Sylvian artery, had been lacerated, and it would appear from Dr. Duncan's statement that the cerebral substance in the Sylvian region was greatly injured. He had no doubt that this part coincided with the foot of the ascending frontal and the posterior part of the third frontal convolution, in which are the motor-centres for the speech muscles and for those of deglutition, etc. The absence of any mark of injury in the vicinity of the fissure of Rolando, accounts for the persistence of muscular power in the arms and legs. He regarded the case as one of much interest, in confirmation of the now so universally admitted doctrine of cerebral localization.

TREATMENT OF INFECTIOUS SORE THROAT.

I always administer an emetic in the beginning. As long as vomiting lasts and the tongue appears coated, I give as little nourishment as possible. All my patients were young and vigorous, so that, instead of stimulating, I had more than once the

idea of bleeding, and would have done so, on account of the active inflammation, had not the feeling of general debility which attends these cases restrained me. This period usually continues to the third day, when, the irritability of the stomach having ceased, I let them take fluid but nutritious food, returning to solid aliment as soon as the condition of the pharynx permits its being swallowed without injury to the inflamed parts. I further advise the patient to use the following gargle every ten or fifteen minutes:

R—Acid salicylic,	℥ j.
Acid carbolic,	℥ xxiv.
Sodii borat.,	gr. lxx.
Glycerine,	f ̄ ℥ j.
Aqua distillat.,	f ̄ ℥ xj.—M.

Sig.—Use as a gargle.

Internally I order a teaspoonful, in half a tumblerful of water, of this medicine:

R—Quinine hydrochlorat,	gr. xxxvj.
Tinct. ferri chlorid.,	f ̄ ℥ j.
Acid muriat. dilut.,	f ̄ ℥ ij.
Tinct. cardamom comp.,	
Glycerine,	
Syr. aurant. cortic., aa q.s. ad.,	f ̄ ℥ iij.—M.

This is taken every three or four hours until the more moist appearance of the tongue and the general condition of the patient indicate amelioration of the symptoms, when the size and the frequency of the doses are rapidly diminished. As soon as the first indication of disturbance of the urinary function sets in, I prescribe a teaspoonful of infusion of digitalis, to be taken every four hours. When the secretion has been re-established, I still continue for one week longer the same dose; for another day the patient is directed to take it but three times daily, and then this medicine is stopped, having achieved its purpose. If the pain in the neck or in the shoulder be very severe, I have found the best result from this liniment:

R—Chloral hydrat.,	℥ j.
Camphoræ,	℥ ss.
Ol. amygdal.,	f ̄ ℥ j.—M.

Sig.—To be applied with a camel's hair brush to the painful parts, the application to be renewed on return of pain.

Besides paying attention to the bowels and employing general measures, as regular feeding, cooling drinks, sponging of the body several times daily, etc., the above contains the whole treatment. For the sleeplessness commonly met with in the beginning I have ceased to prescribe, as experience has taught me that the patients feel better, regain sooner their natural sleep, and recover more quickly, when no hypnotic whatever is employed.—*Hugo Engel, M.D., in Phil. Med. Times.*

CHARCOT'S JOINT DISEASE.

[Dr. A. Sydney Roberts, of Philadelphia, gives a report of six cases of Charcot's joint disease in the *Med. News*, Feb. 14, 1885, from which we select the following case (iv), with illustration.] ED.

Dr. A. A. Y., male, æt. 65, resident of Hammon-ton, N. J. Examined the patient with Dr. S. Weir Mitchell on January 16, 1885. For the substance of the following notes I am indebted to Dr. Wood-nutt.

Hereditary history of patient excellent. He had always been strong and healthy during youth, and up to 1865, though a hard-working farmer. An army life, and three years of extreme exposure prior to the close of the war, found him suffering in 1865 from sharp, wandering pains in the upper and lower extremities; never noticed, however, in



the articulations. Loss of power followed in the right leg. Three years later suppurative arthritis attacked the metatarso-phalangeal articulation of the right great toe, and last phalanx of left ring finger, sequestra coming away in each instance.

During 1870 the patient first noticed an œdematous swelling of the right elbow; following shortly upon this, the wrist joint of the same arm gradually and painlessly enlarged. Then a distension of the capsule of the right knee-joint succeeded. The enlargement of the latter articulation was more

rapid than either the wrist or elbow. Rheumatic pains in the joints accompanied the swelling and deformity.

The left limb has been comparatively exempt from pain. Recently, however, the capsule of the knee-joint has become distended and elastic. The elbow tumor has diminished somewhat in circumference during the past four years.

During the past year the distal phalanx of the right index finger has gradually atrophied, without inflammation, and is entirely wanting. The nail and finger end are normal, though somewhat shortened. Pain, at present, is chiefly in both feet, paroxysmal and erratic, often attacking corresponding points on the legs.

The present appearance of the right elbow and knee joint enlargements exhibit an irregular nodulated hypertrophy, bearing no resemblance to normal joint outline, and consisting chiefly of osteophytes and abnormal increase of synovial fluid. Motion preternaturally free in all directions; structure of joints apparently entirely destroyed.

Remarks.—The joint lesions first appeared in this patient after ataxia had become established. The appearance of the affected elbow and knee is that of an enormous nodular hypertrophied mass of bone, doubling their normal circumference, associated with synovial distension of the capsule. Osteophytes readily movable with the capsule, and varying in size from a pigeon's egg to that of a turkey.

The atrophy of the distal phalanx of the right index finger is especially to be noted. It is the first instance of complete absorption of the diaphysis of bone that I have had an opportunity of observing

PLASTER JACKET—NEW USE FOR.

Dr. McLellan, of St. Marys, Kas., gives the following in the *Lancet and Clinic*, Cin.:— In reading of the uses to which the plaster jacket is put, I have never seen it recommended for the relief and cure of weakened and painful conditions of the spinal muscles, caused by injury, disease, etc., and I think I can make myself more clearly understood by relating two instances from among others, not only where it gave instant relief, but performed a permanent cure. While I was yet a student, (1869, Jan.) I suffered from an attack of typhoid fever, which ran its natural course, and I was convalescent in about eight weeks, and by over-exertion I suffered a relapse, which lasted much longer than first attack. When I got able to be around, I suffered untold agony from pain in the lumbar region and down the course of right sciatic nerve, and at times along the Psoas Muscle, and if I was not near something to catch hold of, would fall, for I could not endure the pain. Cupping, blistering, and all external as well as internal remedies, were

used, but all the relief I could get was from hypodermics of morphia, and I had to take from three to four per day to make living endurable, when I thought the plaster jacket might give me support and relief, and without the aid of anyone I applied a jacket to myself by standing in the position most comfortable, (which was perfectly erect). As soon as the plaster set, I could go around without any pain, and I stopped the morphia then and there, which had got to be considerable, and had no more pain. In less than three months I was perfectly well, and had gained more than thirty pounds, and used no other remedy than the jacket.

CASE 2.—In December, 1883, S. H., aged 19, spare build, came to me, suffering intense pain in the lumbar region and down course of both sciatic nerves. At times the pain was so severe that he would shake as though he had an ague chill. He stated that in September of same year, while making hay, he was helping to put a hay ladder upon the waggon, when the one that was helping him let his hold slip, and all the weight came on him. He sprained the muscles of his back, which grew worse and worse, and, as he stated when I first saw him, he did not want to live the way he was, and as he had already passed through the hands of about three doctors, all regulars, I took it for granted they had used all the usual remedies, so I thought I would try the plaster jacket, and I did so, with the same happy result, no more pain and a rapid convalescence.

OVARIOTOMY IN ENGLAND.—In these days, when continental journals vie with each other in publishing disagreeable remarks about England, it is pleasant to find how, on the other hand, writers in the United States are almost unanimous in sounding praises of our government, our institutions, our towns, our country, and our surgery. *Harpers' Monthly* has just discovered beauties of landscape in the Regent's canal, whilst, in the *Atlanta Medical and Surgical Journal*, the distinguished Dr. Robert Battey devotes an article to a subject which has been looked upon with more pride and interest than that useful waterway by qualified and unqualified Britons, namely, the progress of ovariectomy. The extraordinary results which have been obtained in Great Britain within the past three years, seventy-three consecutive operations in the hands of one surgeon, and seventy-six in the hands of another, without a death, are well calculated, observes Dr. Battey, to excite both astonishment and admiration, American results being far less satisfactory. Dr. Battey, enters into a consideration of the conditions of our success. Experience he considers to be the first of these conditions. If the best results are to be obtained in America, ovariectomy must, he believes, be put into the hands of a few, and the

general practitioner must forego the ambition of swinging here and there an occasional scalp to his girdle. The second condition is "clean hands and appliances;" the third, a clean apartment and bedding. The fourth is "pure atmosphere and free ventilation;" and Dr. Battey's allusion to "the upper floors of buildings in elevated urban localities, with surroundings as salubrious as circumstance will admit," probably refers to the Samaritan Free Hospital. The fifth condition is thorough cleansing of the abdomen. Dr. Battey agrees with those English, Scotch, and Irish operators who employ the drainage-tube when the "toilet" of the peritoneum is from any cause incomplete. The sixth condition is skilled nursing and quietude; the seventh, early operation; the eighth, complete intraperitoneal ligature of the pedicle. The last condition of success is antiseptic solutions and spray. He admits that "the results obtained by Dr. Bantock, in London, and Mr. Lawson Tait, in Birmingham, seem to show conclusively that the use of these solutions is not indispensable to the attainment of the best success. They have both shown by their work that scrupulous attention given to the cleansing of hands, instruments and sponges, not only prior to operating, but frequently during the progress of the operation, is sufficient. The frequent removal of the blood from hands and implements appears to protect the abdomen from septic influence." Dr. Battey then speaks of Dr. Keith's objections to the spray. Nevertheless, Dr. Battey himself is not inclined to give up complete antiseptic precautions. He has never had a case of carbolic acid poisoning, and concludes by observing: "To the criticism that carbolic solutions weaker than one to twenty have been shown in the laboratory to be impotent for the destruction of bacteria, I answer that I am seeking by its use only the restoration of my patients to health, and the mortality in my hands since its use has dropped from twenty-five per cent. to zero. This, for me, is sufficient reason for the continuance of the method, and for the rejection of all other substitutes, until such time as more complete demonstrations shall place a clearer light before me." —*Brit. Med. Journal*.

CHLORIDE OF GOLD AND SODIUM IN SOME NERVOUS AFFECTIONS.—In an interesting paper on this subject (*Medical News, Maryland Medical Journal*), Dr. Roberts Bartholow relates some important facts bearing upon the use of gold as a therapeutic agent. Gold is mentioned as a valuable remedy in the treatment of melancholy in medieval history, and afterwards it was used by the Arabians and Italians. Its therapeutic powers are grouped under three heads:

1. According to its so-called alterant effects.
2. According to its action on the nervous system; and

3. According to its urino-genital properties.

Referring to the preparations used, Dr. Bartholow prefers the double chloride of gold and sodium, which he prescribes in the dose of one-twentieth of a grain. In this quantity, twice or three times a day, it appears to have, as its primary action, the power to promote constructive metamorphosis, to improve the globular richness of the blood; and to increase tissue-strength. The tissue yielding most readily to its use are the connective, and especially those of pathological formation. Hence the remedy is considered especially useful in sclerosis, whether nervous, hepatic or renal. In posterior spinal sclerosis, and in chronic interstitial nephritis, Dr. Bartholow has found the gold salt very efficacious. When used in locomotor ataxia, early and persistently, it has seemed to him to have the power of arresting the disease. Dr. Bartholow has observed excellent results following the use of the gold chloride in many cases of fibroid kidney. In a form of hypochondriasis, coincident with the onset of degenerative changes in the cerebral vessels, he has found gold and sodium chloride very effective. When persistently used, the uneasiness in the head, the vertiginous and other abnormal sensations subside, the mental oppression at the same time clearing up.

In certain affections characterized by spasm, as asthma, laryngismus stridulus, and singultus, Dr. Bartholow has seen this remedy act surprisingly well. In urino-genital affections the gold has great value, and cases of chronic albuminuria have been observed in which the curative effects of the remedy have been most conspicuous.

In certain cases of sexual debility, in dysmenorrhœa with scanty menstruation, and in chronic metritis the persistent administration of gold and sodium chloride has done much good. Dr. Bartholow indicates the direction in which the remedy promises to be useful, but is of the opinion that wider and more varied experience is necessary to fix its real position. It seems to us from this statement, made by Dr. Bartholow, that the remedy in question possesses very valuable powers, and is destined to awaken considerable interest. Its actions and uses are worthy of most careful study.—*Medical Review.*

RUPTURED EXTRA-UTERINE PREGNANCY.—Another woman has passed from health to the grave in a few hours; another home has been made desolate; and another victim to delay and palliative hypodermatics of morphia and brandy-and-water in drachm doses has been added to the list, already too long, of cases that have been lost for want of surgical treatment.

A case has been recently reported, in a western medical journal, in which the symptoms of rupture of an extra-uterine fetal sac were complete, and the diagnosis of extra-uterine pregnancy was con-

curred in by three practitioners, and the following treatment adopted: "Sulphate of morphia in one-sixth-grain doses, hypodermatically, to control the pain, and brandy, both by the mouth and under the skin, as a stimulant. A sinapism over the stomach and bowels assisted in giving some measure of relief." The patient died in sixteen hours and a half. Nothing is said of an attempt to control the hemorrhage, which every one must have known was draining away the woman's life. Nothing is said of a desire to open the abdominal cavity to stop the hemorrhage and remove the foreign body. Is the recorded experience and the teachings of the surgical leaders of the day to go for nothing? Are there any who think that a patient in this situation dies of aught else save hemorrhage, and controllable hemorrhage? If the hemorrhage be not controllable, why do the patients live for sixteen and twenty or thirty hours after the rupture? Are there those in the profession who do not know that the mere exposure of the abdominal cavity to the air will often check a hemorrhage which would otherwise prove fatal in the closed cavity? Surely in these days of great and brilliant triumphs in abdominal surgery, when patients recover after intestinal wounds, and resections, when the most desperate "forlorn hopes" recover, one should not hesitate to open the abdomen in a case of this kind, when two or three ligatures and some clean water are all that are required.

There is no palliative measure for a ruptured extra-uterine cyst; there is no expectant treatment; and there is no other way known to medicine by which a woman in this condition can be reasonably expected to survive save by the prompt use of the knife—and there is no reason for thinking that she would die if this be resorted to in time. And until she is practically dead it is never too late to try and save her.—*N. Y. Med. Record.*

SUPERIOSTEAL AMPUTATION.—A paper by Dr. Nicaise, read at the International Medical Congress in Copenhagen, is published in the *Revue de Chirurgie*, No. 12, 1884. In 1859 M. Ollier first demonstrated the utility, in amputating, of preserving periosteum, in order to close the medullary canal, and to favor union by primary intention. At this period, however, the suppuration that almost constantly attended the healing of stumps rendered attempts to preserve this membrane quite useless, and so for a time they were abandoned. Since the introduction into surgery of Lister's antiseptic method, further trials have been made under the improved conditions, and the practice has been advocated by Esmarch, Volkmann, Maas, Trelat, and others. Since 1881, Dr. Nicaise has in amputating always preserved a portion of periosteum beyond the end of the bone. As this

membrane retracts very much when detached from its bone, it is thought always necessary to take up a long 'cuff,' the length of which should be about equal to the diameter of the bone at the point of section. Esmarch and Maas bring together the free edges of the process of peritoneum by a suture of prepared catgut; Nicaise does not apply a suture, but allows the long cuff to form over the end of the bone a kind of hood. It has been proved by experiments on animals that a flap or loose process of periosteum rapidly closes the open end of the medullary cavity, and that on the inner surface of this occluding membrane a thin layer of osseous tissue is formed. M. Nicaise alludes to a case of amputation of the thigh for chronic disease of the knee in a tuberculous man, aged 42. After death, which occurred twenty-nine days later, when the stump had almost entirely healed, the lower extremity of the divided femur was found completely closed by a septum of thickened and granular periosteum, above which was a layer of newly formed bone-tissue, about one-fifth of an inch in thickness. It has been shown by LeFort and Trelat that a minute flap of muscular tissue brought over the end of a divided long bone will contract adhesions, close the medullary cavity, and even form a thin layer of osseous tissue. M. Nicaise, however, holds that, when a flap of periosteum is applied, the end of the bone is in immediate relation with a membrane that physiologically is best adapted to the purposes of protecting and forming osseous tissue. It has been objected to the preservation of periosteum in amputation, that this practice favors the formation of irregularly shaped osteophytic growths. Such growths, however, according to the author, are formed only after suppuration in the stump, or osteitis at the extremity of the bone.—*London Med. Record*.

POISONED BY COLORED STOCKINGS.—Again and again have medical journals warned against the wearing of cheap colored underwear. As these materials generally consist of cotton, at least to a great extent, the coloring stuff is not always an innocuous; but frequently a dangerous one.

The latest case of this kind is reported by Dr. O. Seifert, in the *Wiener Med. Wochenschrift*, 1885, 38. A young lady æt. 26, had been wearing stockings, which had been colored by an anilin-red, containing a large percentage of arsenic. She was suddenly seized with all the symptoms of a gastro-enteritis and an acute hæmorrhagic nephritis; besides, an eczematous skin-eruption made its appearance on the dorsal surfaces of both feet. The treatment first gave a very unsatisfactory result, until the cause was discovered, when the patient was cured of her disease within three weeks. The urine, however, for a considerable time afterwards, contained a small amount of albumen, though this finally also disappeared.

There ought to be a sanitary inspector, not only for all food—whether solid or fluid—that is offered for sale, but also for articles of wear. The demand for cheaper goods, and the great competition, has made many manufacturers reckless, and they seem to care very little if they injure the health of individuals, if they can only produce goods which are cheap and showy. As not every buyer can be an expert, purchasers ought to be protected by law, making the poisonous or any adulterations of any article offered for sale, a criminal offence, and appointing inspectors for the purpose of investigating and discovering all dangerous swindles of that kind. Meanwhile, it would be best for all buyers to avoid all cheap articles, which mainly attract attention by their bright colors. In wool, the danger is not so great, as woolen materials may be easily dyed by innocuous vegetable coloring matters.—*Med. & Surg. Reporter*.

THE TREATMENT OF WHOOPING COUGH.—The treatment of this disease should be of two characters, one of which is addressed to the catarrhal and the other to the nervous element. Considering the bacterial nature of the disease, antiseptics form one necessary class of agents for treatment. Oxygen in the form of an abundance of pure air is always indicated. The sick-room should be kept at a uniform temperature and the air moistened with spray, either of simple steam vapor of lime, of carbolic acid, corrosive sublimate, listerine, muriate of ammonia, or cocaine. Thymol, eucalyptus or quinine, may be used in this form. The following formulæ for use with the spray are recommended:

R.	Acidi carbolic cryst.	3 grs.
	Sodii bi-boratis	
	Sodii bi-carb.	aa 20 grs.
	Glycerinæ	1 oz.
	Aquæ	1 oz. M.
R.	Thymol	15 grs.
	Alcoholis	3 dr.
	Glycerinæ	½ oz.
	Aquæ	34 oz. M.

The inhalation of a few drops of ether or chloroform is recommended when the paroxysms are violent. Of emetics, alum is thought to be the best, a quarter or half a teaspoonful being given with syrup or honey, and repeated if necessary. In the mean time the child may be placed upon its stomach, with the head lowered. Of nervous sedatives, belladonna is the best for this trouble, and may be given in suitable doses of the tincture, or in the form of the sulphate of atropia, $\frac{1}{100}$ of a grain at a time, increased until the pupils are dilated. The bromides of sodium, ammonium, or potassium may also be given, and in many cases chloral is very useful. Of the latter, for a child one year old, two grains may be given at bed time. Of

quinine, a grain may be given several times during the day with good effect. The foregoing list may be increased by the addition of pilocarpine, benzoate of sodium, salicylic acid, sulphur, cantharides, calomel, and soda, etc. Counter-irritation is an important measure, a mixture of croton oil, oil of amber, and oil of cloves, mixed with sweet oil, and rubbed upon the neck or chest, being recommended. The bowels should be kept freely open, heat applied over the lungs if they appear to be implicated, and a nourishing diet with a suitable quantity of stimulants administered.—*Archives of Pediatrics*.

INCONTINENCE OF URINE IN CHILDREN.—Eustace Smith gives the following in his recent work: "Of medicines which diminish irritability, belladonna takes the first place, but it is important to be aware that this remedy to be effectual, must be given in full doses. Children have a very remarkable tolerance for belladonna, and will often take it in surprising quantities before any of the physiological effects of the drug can be produced. In obstinate cases of enuresis the medicine should be pushed so as to produce dilatation of the pupils, with slight dryness of the throat. In children of four or five years of age, it is best to begin with twenty-five or thirty drops of the tincture of belladonna, given three times in the day, and to increase the dose by five drops every second or third day, of course watching the effect. Ergot is another remedy which is often very successful. For a child of the same age, twenty drops of the fluid extract may be given several times in the day.

Bromide of potassium, benzoic acid (dose, five to ten grains) and benzoate of ammonia, digitalis, borax, cantharides, camphor and chloral have all been recommended as specifics in this complaint. Sometimes a combination of several drugs seems to be more effectual than one given alone. I have lately cured a little girl, aged four years, who had resisted all other treatment, with the following draught given three times in the day:

R Tinct. belladonna.....gtts. j.
Potas. brom.....grs. x.
Infus. digitalis.....3 ij.
Aquam ad.....3 ss.
M. Ft haustus.

When the incontinence continues in the day as well as at night, strychnia should be combined with the sedative, so as to give tone to the feeble sphincter. In these cases, too, cauterization of the neck of the bladder, with a strong solution of the nitrate of silver (℥j—3 j. to the ounce of water) has been found successful."

VALUE OF "THE DIAGONAL LINE" IN THE DIAGNOSIS OF DISTENSION OF THE GALL-BLADDER.—John W. Taylor, F.R.C.S., Birmingham and Midland Hospital for Women, says: In an article on

cholecystotomy in the *British Medical Journal* of January 31, 1885, I wrote as follows: "An important aid to diagnosis will, I think, be found in recognition of the diagonal line in the direction of which the gall-bladder enlarges. This is to be traced from the normal position of the larger end of the gall-bladder (near the tip of the cartilage of the tenth rib on the right side) to the opposite side of the abdomen, crossing the middle line slightly below the umbilicus."

Since writing the above, I have had some additional opportunities for testing the value of this aid to diagnosis. On February 15, 1885, I was asked to see a case of abdominal tumor by my friend Dr. Drury. There was no jaundice, and but little clinical history to be obtained in the limited time at my disposal. Finding, however, a well defined, hard, but rather resilient tumor, the longer axis of which exactly corresponded to the diagonal line described, I had no hesitation in diagnosing the case to be one of distension of the gall-bladder.

This opinion (in which Dr. Drury concurred) was considered erroneous by another surgeon of large experience, who saw the case subsequently: and, as the chief reason for my opinion was the sign which is the subject of my communication, the case became of some special importance to me as a test.

On March 26th Mr. Tait operated. The tumor proved to be a distended gall bladder; and a large number of calculi were removed from it, two of these being of enormous size.

I should like to again draw the attention of the profession to this diagnostic line, as I believe it to be trustworthy and useful.—*British Med. Jour.*, April 11th.

BELLADONNA INJECTION FOR GONORRHOEA.—Some thirteen years ago an officer on board one of the vessels of the Indus Steam Flotilla consulted me for a bad gonorrhœa with intense pain on micturition, and intolerable chordee at night. The case was urgent, and I ordered an injection composed of seven ounces of water, an ounce of mucilage acacia, twenty grains extract of belladonna, and twenty grains of sulphate zinc, a teaspoonful to be injected immediately before and after micturating, and a similar amount the last thing at night; great care to be used in passing the injection fully down as far as the pain is most intense. An ointment of spermaceti and mercurial ointment, four drachms each, and ten grains extract belladonna, ten grains powdered opium, as a paste to be smeared along the perineum and around the crura penis at night. Patient left next morning, having had no chordee that night, and the pain of micturition disappeared by using the injection. Within a week there was complete cure. From that time I have had numerous gonorrhœal cases of every type and stage, and without exception with unfa-

ing success. Not long since a shop assistant presented himself with a bad gonorrhœa, high fever, inflamed testicle and chordee at night. With the application of the belladonna and opium ointment the chordee did not appear, and in four days after using the injection the running ceased, but after the first application the pain and running were much lessened. A suspensory bandage was worn, and with the daily use of the mercurial and belladonna and opium ointment the patient was quite well in three weeks. Patients have always stated that it is the injection, and not the ointment, which stopped the chordee. I have tried the anodyne treatment in various classes of people, from the dissipated paupers of the Eastern bazaars to the well-fed *roue* in the West ; in the acute and in the chronic and gleet stages ; in first attacks, and in those making one of a series ; and in cases complicated with inflamed testicles and chordee ; and I have no hesitation in saying that I have not witnessed anything to contra-indicate it nor to mitigate its success.—John Roche, M.D., in *Medical Press*.

THE INJECTION OF HOT OR COLD WATER IN UTERINE HÆMORRHAGE.—Dr. Schwarz relates a case of post-partum hæmorrhage which was controlled temporarily by an injection of water at a temperature of 120° F., containing two and a half per cent. of carbolic acid. The bleeding began again, however, and could not be arrested by further hot-water injections. A trial was then made of ice-water with perfect success. In other puerperal and non-puerperal cases, after failure with hot water, the author obtained most satisfactory results with cold injections. Dr. Graefe has also had several cases in which he found cold irrigations to answer the purpose after hot water had failed. He regards the styptic action of hot water as due not only to the swelling of the tissues which it causes, but also to a certain degree of muscular contraction in the uterine walls. The former is not sufficient in itself to arrest the hæmorrhage unless aided by muscular contraction. When cold water irrigations follow those previously made with hot water, strong contractions of the uterine muscles are excited, but the œdematous swelling caused by the hot water can not be so rapidly overcome, and hence the two conditions most favorable for arresting the hæmorrhage are present. In the same way when hot injections follow cold ones, the irritation to the muscular tissue remains, and to it is added the swelling of the tissues above mentioned. If only one be used, Schwarz prefers the cold water, as having the advantage of absolute safety. Hot water, if too hot, may cause a paralysis of the uterine muscular tissue, and if not hot enough will only increase the hæmorrhage. If a trial with one temperature be unsuccessful, the use of the opposite will almost certainly control the bleeding.—*Schmidt's Jahrbucher*, No. 7, 1884; *Med. Record*.

SWALLOWING OF ARTIFICIAL TEETH.—Artificial teeth have probably been often swallowed. Too hard for digestion and not provided with sharp-pointed edges, as a rule, they cause very little inconvenience. More dangerous is the swallowing of whole sets, as in such a case a plate, with all its hooks and pointed edges, has to pass through the pylorus and the ilio-cæcal valve. If it were possible, after such a plate has been inadvertently swallowed, to send some substance after it that could envelop the pointed and "hooky" plate with a material which might remove the sharp points, the greatest danger would be removed. But thus far this substance has been a desideratum unfulfilled. In the April 13, 1885, number of the *Deutsche Med. Zeit.*, however, we find a communication which, on account of the ingenuity of the procedure, and of its complete effect, is highly interesting and deserves further dissemination through the columns of the *Medical and Surgical Reporter*.

A dentist named Geisselbrecht, in Fürth, was sent for one night by a servant girl, who, during sleep, had swallowed her artificial teeth. The set consisted of a rubber plate with four canines and two bicusps, which plate was attached by the aid of gold clamps to the natural teeth. On examination, the neck of the girl was found to be swollen and painful to the touch in the region of the larynx. The examination of the pharynx gave no result ; the set had disappeared ; but with the use of the œsophageal sound it could be felt. But as the plate had already passed too deeply, there was no prospect of its being extracted, and G. pushed it with the sound into the stomach through the cardiac orifice.

Now comes the interesting part of the procedure. That the plate might pass on through the intestinal canal without injuring the latter, G. induced the girl to swallow a lot of cotton thread (spool cotton), which was first cut into small pieces and incorporated in the white of an egg beaten to snow. The intention was to have the threads steeped into the white of the egg, wrap themselves around the sharp points of the plate and thus prevent their injuring the intestines.

The result has been a brilliant one ; four days later the girl brought the ominous plate, and the latter was found to be completely enveloped, over-spun, as it were, by the cotton threads. The patient said that she had no pain, or any other inconvenience either, while the plate was resting in the bowels or during its passage out.—*Med. and Surg. Reporter*.

THE TREATMENT OF CHOLERA.—The current number of the *Practitioner* contains the concluding paper of the interesting series that have been published in that journal by Drs. Lauder Brunton and Pye-Smith, in the course of which they have dis-

cussed the present knowledge of the pathology of cholera. Speaking of the treatment of the disease, they divide remedies into five classes: of these, three contain remedies which act on the intestine. They are—1. Those which are likely to have an antiseptic action on the intestine by destroying any organisms there present, such as carbolic acid and its allies, sulphurous acid, nitro-muriatic acid, hyposulphites, permanganates, chlorine, chloralum, turpentine, salts of copper, boracic acid, calomel, and corrosive sublimate. The cholagogue action of calomel is thought to be of service by inducing indirectly the antiseptic action of bile. 2. Those remedies which will tend to remove the cholera poison, whether it consists of living organisms or of some chemical substance, exemplified by the treatment by castor oil and other purgatives. 3. Those remedies which will counteract the effect of the poison upon the intestinal canal, as opium, morphia, ice water, belladonna, cannabis indica, chloroform, chloral, carminatives, and astringents. 4. Remedies which will tend to eliminate the poison from the system, as copious draughts of water (as diuretic) and purgatives. 5. Those remedies which will counteract the effects of the poison—viz., intravenous injection of saline fluids and other substances, and various measures to restore the circulation by acting upon the skin. In dealing with the premonitory diarrhoea, Cantani's method of injections, by means of the long intestinal tube, of laudanum and tannic is described. The authors consider that Ferrán's results of inoculation are more favourable than could have been expected, and point out the following as "directions in which further researches after a remedy for cholera are most likely to prove successful":—"1. The discovery of an antiseptic which will destroy pathogenic organisms in the intestines and prevent the formation of the cholera poison, while they are not themselves poisonous. Corrosive sublimate is a sufficiently powerful antiseptic, but it may itself prove poisonous to the patient as well as to the pathogenic organisms. It is possible that amongst the members of the aromatic group of bodies substances may be found having the desired properties. 2. The discovery of some substance which will antagonise the action of the cholera poison after its absorption. As a preliminary step in this direction further experiments are needed in the nature and action of alkaloidal substances obtained from cholera dejecta, as well as from artificial cultivations in various media and under various conditions, electrical and otherwise. 3. Observations on the effect of stimulation of the mesenteric plexus by currents passed through the uninjured abdomen in poisoned animals and in patients suffering from the disease."

—*Lancet*.

TREATMENT OF SCROFULOUS NECK.—Dr. Clifford Allbutt, in a recent lecture, affirms that the

chronic enlargement of the glands of the neck, known as scrofulous neck, is secondary to irritation in the associated mucous membranes, and absorption therefrom; the chief of these being the mouth and throat, and the next in order the nasal, aural, and ocular surfaces; and sometimes from irritation upon the skin of the face and head. Speaking of the treatment of these cases, the author says that a residence at Margate, together with careful dieting and nursing, is the best means of cure in cases which are not far advanced. The cautious use of mercury, such as the solution of the bichloride, with tincture of iron, is very good, unless the inborn frailty be very marked; and iodides with iron are likewise valuable. External applications should be used with caution. So soon, however, as the glands become adherent, either to each other or to the surrounding tissues, then it is most desirable to call in the surgeon, and to extirpate every caseous gland or portion of a gland. Mr. Teale has devoted much time and has had great experience in operating on these cases, and it is due to the combined exertions of Dr. Allbutt and Mr. Teale that numerous cases have been restored from a state of misery to enjoy a life of comparatively good health. The scar remaining after the operation is small, and after a year or two not very noticeable, provided the drainage be not kept up too long; it is better to risk a second operation than to keep the drainage-tube in for too long a period.

DIFFERENTIAL DIAGNOSIS OF SIMPLE AND TUBERCULOUS MENINGITIS.—In an analysis of a number of cases of meningitis occurring in the Children's Hospital at Stockholm, Dr. O. Medin endeavours to formulate the points of difference in the tuberculous and simple forms of the disease. Tuberculous meningitis attacks only those children already suffering from tuberculosis of other parts, while simple acute meningitis occurs usually in previously healthy individuals. The former manifests its onset by convulsions, frequently strabismus, and dilatation or contraction of the pupils. Vomiting is frequent at the commencement, diarrhoea is the usual condition, and constipation is rare. The abdomen is never flat. The simple form begins with somnolence, twitchings, sudden changes of color in the face, and hyperesthesia. More frequently than in the tuberculous form we meet with the hydrocephalic cry, and a paralysis limited to the arms or to the face. The tuberculous variety is always fatal in its termination.—*London Practitioner*.

TREATMENT OF VARICOCELE BY EXCISION OF A FOLD OF THE SCROTUM.—At a recent meeting of the Académie de Médecine, Hortaloup recommended a plan of operation which he has practiced for several years with success. He pushes the

testicles upwards, and seizes with a long pair of forceps a fold of scrotum containing the plexus of the spermatic veins. Deep sutures are passed immediately in front of the forceps and fixed by leaden tubes; a row of superficial sutures is then placed a little nearer the edge of the fold, which is afterwards excised. The superficial sutures are tied, and an antiseptic dressing is applied to the wound. M. Horteloup has performed this operation in eighteen cases without any serious accident, and expresses himself much pleased with the ultimate results—*London Med. Record*, April.

DIAGNOSIS OF GONORRHOEA IN THE FEMALE.—Martineau, at a recent meeting of the Paris Obstetrical and Gynecological Society, stated a most important fact by which specific can be distinguished from simple vaginitis. It depends upon this that in the specific form of the disease the pus is always acid, while in the simple it is alkaline. It is very easy, therefore, to decide by a piece of litmus paper as to whether a woman is or is not suffering from gonorrhoeal inflammation.

This sign will prove of value, too, in determining, when rape has been committed, whether the person committing the crime was affected with gonorrhoea, for then the vulvitis would be characterized by an acid discharge, while in the simple form of the disease the discharge is alkaline.—*Med. News*.

ACUTE ABSCESS.—Prof. S. W. Gross says it is a mistake to apply a poultice to an abscess after its contents have been evacuated. The endeavor should be to prevent and not encourage the formation of pus. To do this the cavity of the abscess should be syringed out with a 1 to 1000 solution of mercuric bichloride, and the walls brought together by compresses and bandage, and union allowed to take place by granulation. If the abscess be of large size a drainage tube should be left in for a couple of days until the serous oozing has been reduced to a minimum. The tube should then be taken out and the walls brought close together. If the healing process be delayed by the development of flabby oedematous granulations they can be stimulated to healthy action by the injection of a three per cent. solution of carbolic acid or the application of chloride of zinc gr. ii., aqua 3j.—*Med. Bulletin*.

TREATMENT OF SPERMATORRHOEA.—Dr. Nowatschek reports in *Schmidt's Jahrbucher*, January, 1881, a case of spermatorrhoea consequent on typhoid fever, the diagnosis resting on the presence of spermatozoa in the fluid which was constantly oozing from the urethra. Iron, quinia, and cold applications to the genitals were tried in succession with some success, but a cure was not accomplished. Lupulin, camphor, and bromide of potassium were

without effect. Atropia was then employed, and the patient was completely cured in five days. The author cites a second case where he was equally successful with the hypodermic injection in the perineum of a one per-cent. solution of atropia.—*Four. de Med. de Paris*.

ANTIPYRIN.—This new antipyretic, is now advanced to the position occupied by quinine, salicylic acid, etc. Dr. A. C. Girard, assistant surgeon in the U. S. Army, in the *Medical News*, speaks very positively in regard to its usefulness as an antipyretic. He says it reduces the temperature without evil concomitant; the fall of temperature begins one or two hours after ingestion of the remedy, and its effects last from seven to twelve hours. It does not seem to shorten the disease for which it is given, but surely lowers the temperature, and thus prevents the rapid waste consequent upon the high temperature. The dose advised is from fifteen to thirty grains, or even more.

A METHOD OF TREATING PRURITIS ANI.—A correspondent of the "*British Medical Journal*" suggests the following plan of treating this distressing affection: Wash the external parts well with warm water, and inject a small amount of water into the rectum. Then introduce a ball of cotton saturated with a lotion consisting of:

Carbolic acid.....	20 grains;
Laudanum.....	4 drachms;
Dilute hydrocyanic acid.....	2 "
Glycerin.....	4 "
Water, enough to make.....	4 ounces.

The pledget should be removed before defecation, and a fresh one introduced after the act.—*N. Y. Med. Journal*.

RAPID BLISTER.—It is sometimes desirable to produce a small blister quickly. For this purpose nothing is better than concentrated water of ammonia (*aqua ammoniæ fortior*). Put a few drops of it in a watch crystal, or any receptacle of the sort, cover it with a pledget of absorbent cotton, invert on the spot to be blistered, and press closely. In half a minute or so a red circle will appear on the skin around the edges of the confining vessel. It is an evidence that vesication has taken place, and the blistering material can be removed. The blister should be treated in the same manner as one obtained from cantharides.—*Southern Clinic*.

COD-LIVER OIL AND LIME-WATER IN SCALDS OF THE THROAT.—Palmer ("*Practitioner*"), referring to the frequency with which young children are scalded by drinking from the spout of a tea-kettle, speaks highly of the therapeutical value of teaspoonful doses of lime-water and cod-liver oil (equal parts). In a severe case treated by him the patient received a teaspoonful of this novel "car-

ron-oil" every hour. The pain was promptly relieved, the child was soon able to swallow, and within a few days recovery was assured. The writer does not give a very satisfactory explanation of the *modus operandi* of the remedy.—*N. Y. Med. Four.*

SUPPORTING THE PERINEUM.—In the *Clinique d'Accouchements*, at Paris, Depaul in one of his last lectures said: "I never support the perineum; I am contented with supporting the head of the fetus and preventing it from emerging too suddenly." Often, when the perineum has been supported, it has been found on withdrawing the hand that a rent has been made in the perineum by the hand itself. For this reason Depaul said, support the head, but leave the perineum alone.—*N. Y. Med. Times*, April.

CHRONIC DYSENTERY.—Prof. Da Costa finds sulphate of copper, gr. $\frac{1}{2}$ — $\frac{1}{8}$, four times a day, combined with opium, to be very effective in chronic dysentery. Other remedies he finds useful are bismuth, especially in children; nitro-hydrochloric acid, zinc sulphate, argentic nitrate, iron sulphate, or Monsell's solution (gtt. iij. -v.), or solution of the nitrate (gtt. xx.—xxx.) All except iron should be combined with opium. When other things fail, small blisters over the spot of greatest soreness sometimes do good. The diet should contain no starches, fruits or vegetables.—*Coll. and Clin. Record.*

TREATMENT OF ECLAMPSIA BY WARM BATHS.—Breus has given in the *Archiv für Gynækol.*, Band xxi., No. 1, the result of his observations in seventeen cases, two of which ended fatally. He recommends putting the patient in a bath at 38° C., and to raise the temperature of the water gradually until it reaches 41° C. After that, the woman is wrapped up in blankets, and abundant perspiration sets in. When albuminuria exists during pregnancy, a course of warm baths may prevent the occurrence of convulsions at the time of confinement.—*London Med. Record*, April.

ECZEMA OF THE GENITALS.—

R Potassii chloratis 1.50 gm.
Vini opii 2.50 gm.
Aque puræ 1 litre.

Apply on a compress. To be preceded by a warm sitz-bath or by mild cataplasms if there is a certain degree of attendant inflammation.—(*La France méd.*)—*Phila. Med. Times*, April 18th.

PRURITIS OF PREGNANCY—SULPHUROUS-ACID LOTION.—Dr. Powell, Peckenharn, writes in answer to a query: Presuming "A Member's" patient is not diabetic, I would suggest that she apply to the

parts affected a lotion of sulphurous acid in warm water (half ounce to the half pint), the results of which I have uniformly found successful.—*Brit Med. Four.*

APPLICATION IN ORCHITIS.—The following formula is highly endorsed as a local application in orchitis:

R Iodoformi 5 j.
Thymol gr. iv.
Vaseline 3 j.

M.—To be applied greased on linen.

—*Med. World*, April.

EXTRA-UTERINE PREGNANCY.—In a recent number of the *Brit. Med. Four.*, Mr. Lawson Tait reports three cases of tubal pregnancy, with consequent rupture of the tube, in which laparotomy was performed successfully. Mr. Tait has now saved eight women out of nine in whom a similar condition existed. This is a remarkable record, and we do not know which most to admire, the accuracy of the diagnosis or the promptness with which the emergency was met. In Mr. Tait's opinion all cases of extra-uterine pregnancy are of the tubal variety.—*N. Y. Med. Four.*

HEPATIC COLIC.—In a case of hepatic colic with a tendency to the formation of biliary calculi, Prof. Bartholow prescribed:

R Sodii cholat gr. xxx.—xl.
Extract, nucis vomicæ gr. ijss.

M.—Fiant pil. x. Sig.—One pill ter in die.

The cholate of sodium will help to keep the bile in a soluble condition.—*Med. Bulletin*, April.

DYSPEPSIA.—The following will be found excellent in cases of dyspepsia either chronic or acute:
R Elix. pepsin 3 iss., bismuth sub. nit., 3 i., fl. ext., hydrast, canadensis, 3 iss., Tr. lavender co., syrup, simplex, equal parts, q. s. ad., 3ij. M. Sig.—Teaspoonful 3 three times a day before meals.—*Med World.*

WHENEVER a case of scrofulous disease was presented at his clinic, in the person of a child whose father had been in the army, the late Prof. Gross, asking no further questions, would turn to the class with the single, but significant, remark, "Specific, gentlemen!"

TRACHEOTOMY in diphtheria saves but few persons who take the disease in severe epidemics, according to Dr. Jacobi. This opinion is founded upon fifty consecutive unsuccessful tracheotomies during a period of two years.

DR. LEWIS A. STIMSON has been elected Prof. of Anatomy in the University of the city of New York, to succeed the late Prof. Darling.

THE CANADA LANCET.

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PHYSICIANS' WORRIES.

It would be hard to name a class of men more the victims of worry than medical men. It is not to be presumed that this arises from anything inherent or exceptional in the constitutional make-up of medical men. The young men who come up from every grade of society to learn the mysteries of medicine, are as free from the cares of life, and as buoyant in temperament, as mankind produces. Indeed, we venture to remark, that for unselfishness, present enjoyment of life, and freedom from the forebodings of the ills the morrow may bring, they stand pre-eminent. How then does it come, that so large a number in after life become unhappy, care-worn, and wind up their mortal career at a much earlier period than men of other walks of life? The very fact of medical men dying off, before their time, so to speak, goes a long way to support the commonly-made assertion that the physician leads a life of toil and worry. Of course we all know that there are many exceptions. There are those who, however much they toil, do not worry—and are always cheerful and contented amidst even the most unfavorable environments. Amongst these we may safely class all the octogenarians dead or living, for it is rare indeed that the man who is bowed down from early manhood by a load of anxieties and troubles reaches even his allotted three-score and ten years, no matter what his calling or circumstances in life. It is said, and said

truly as regards mental work, that it is worry and not work that kills. True, the work of the busy physician is anomalous inasmuch as severe physical exertion has to be borne along with the mental strain inseparably associated with the performance of duties, in their very nature weighty and critical, and hence demanding, almost constantly, the full exercise of the intellectual faculties. In this respect the practice of medicine, we believe, is unique. This of itself would, to some extent, account for the anxieties which perpetually harass the conscientious physician, and tend to make him short-grained and grey-haired before his time.

But the struggle for existence is by far the largest factor in the medical man's troubles. As he looks on his wife and children and reflects what little provision he has hitherto been able to make for their future wants; or, worse still, finds himself unable to meet present demands, and yet is obliged to maintain himself and family in a manner becoming their station,—he naturally begins to feel uneasy. "The narrower the pit the fiercer the fight," and the knowledge that others are making a dead set on what is barely enough for himself, is a fruitful source of worry, and to most natures unavoidably so. Under such circumstances he feels it imperatively necessary to guard his little patronage with the utmost care and watchfulness, sparing neither physical nor mental effort to ward off the approaches of those whom necessity compels him to regard as intruders and enemies. And thus has it come to pass, in all civilized countries, that the majority of the members of a humane and noble profession are so hotly engaged in a competition, involving no higher issues than bread and butter, as to rob them of needed rest and recreation, induce feelings of jealousy and enmity, culminating in a state of hopeless, chronic worry. We must not omit to mention that a good many, "blessed with enough and to spare," may also be placed in the above category. It is a pity it should be so, but we all know that our profession has its mercenary members like all other callings, and not a few either. Instead of lending a helping hand to the beginner, or to an unfortunate or distressed brother, they are found engaged in a perpetual war of extermination, waged on the Darwinian theory, that the fittest alone has a right to survive!

It is a subject of common remark, that medical men are more than usually sensitive in the matter

of criticism. This is probably true, but there is a reason for it, and that is, that his reputation is the medical man's whole stock-in-trade. When that is wantonly assailed, as too often happens, but few can stoically remain unmoved. This is all the more difficult, because such adverse criticism usually comes from persons wholly incapable of judging in medical matters, and generally is uncalled for, ungenerous, and foundationless. No calling is so much exposed to the assaults of the ignorant and malicious, and no form of slander is so difficult to disprove, or to arrest on its rounds, as that which falls to the lot of the physician.

We might also refer to the nature of the work the physician has to perform. His mission is not to the gay and happy, but to the downcast and miserable. His path lies through sickness, suffering and death, and the gloom which overhangs such scenes. It would be easy to name other troubles peculiar to our calling, but let this suffice for the present. While most of our worries are inherent to our duties, it must be confessed that they are greatly aggravated by our own imperfections, and instead of unduly magnifying them, it should rather be our aim to reduce them to a minimum, and heroically resolve to endure what cannot be amended. But the picture has another and brighter side. Medical men are messengers of "peace and good will to men," in a less high degree of course than spiritual messengers, but such they are nevertheless. The binding up of wounds, the alleviation of pain, the removal of disease and restoration to health, hope and the enjoyments of this life, is a mission so beneficent and exalted as to afford, in quiet moments, much joy and satisfaction to all who engage in it, and rightly apprehend its true nature. Were more of this spirit to prevail and less of the mercenary, many of the ills of which we complain would disappear, and the profession of medicine would be greatly elevated in the estimation of its membership and the public generally. But such a thought is too Utopian for serious mention in the present utilitarian condition of society.

Charity begins at home, and every man owes a duty to himself and his household. Of the duties thus imposed but few are as important as the cultivation of a cheerful, hopeful disposition. There is wealth, health and happiness in it. To do this successfully, the medical man needs helps. Let

him have some hobby, some means of diversion to lift him for a few hours, at least, out of his well-worn ruts. He should not hesitate, nor consider such time lost, to take a holiday now and again. The freshness and vigor of both body and mind acquired more than compensate for the time and money spent. We owe to our patients the sunshine of a cheerful and happy manner. The sick need encouragement, and all the inspiration to be derived from a hopeful disposition and buoyant spirits. Let the doctor not withhold these potent adjuncts when called upon to prescribe. They are not only cheap but marvelously efficacious as well.

ONTARIO MEDICAL COUNCIL.

The first meeting of the newly elected Council of the College of Physicians and Surgeons of Ontario was held in this city on the 13th ult., and following days. All the members were present, and the business of the College was promptly and faithfully attended to. Dr. Bergin, M.P., of Cornwall, was elected president, and Dr. Douglass, of Port Elgin, vice-president. The secretary and treasurer were re-appointed, and many new names were added to the various standing committees. Some interest was taken by members in regard to those students who went to the North-West as dressers and were thereby prevented from taking their primary examination. After some discussion and supported by the opinion of the solicitor, the Council very wisely decided to allow the students so situated their primary examination. The curriculum was not disturbed, save in one respect, viz., the placing of arts graduates in the same position as mentioned in last year's announcement, *three* years' medical study only being required, instead of four as was proposed last year. In the matter of registration, it was decided to make the registration fee \$25, instead of \$10 as at present. This was deemed necessary, owing to the loss of fees sustained in consequence of a number of students qualifying in Great Britain, who were admitted to registration on their return on payment of the small fee of \$10, while those who took the Council examinations were required to pay \$60. The fees for the primary and final examinations will be correspondingly reduced, so that the fees for those who take the Council examination will be the same as heretofore. The examining board of last year

was re-appointed, no change being considered advisable at present. It is gratifying to observe that the spirit of intermeddling with the regulations of the Council, so much in vogue a few years ago, has given place to a settled determination to make changes only when they appear after due consideration to be essentially necessary in the interests of the college. With regard to the site for the college building, it has been suggested that the Council retain the present site on the corner of Bay and Richmond streets, and erect a large building, three storeys in height; the lower storey to be rented for business purposes, and the upper storeys reserved for the use of the college. The proposal seems a very good one, and a committee has been appointed to consider the whole matter.

NEW INTERPRETATION OF THE CODE.

A committee of the American Medical Association was appointed last year, consisting of Drs. N. S. Davis, Chicago; Austin Flint, sr., New York; H. F. Campbell, Augusta, Ga.; A. P. Garnett, Washington; and J. B. Murdock, Pittsburgh; to report on the interpretation of certain clauses of the "code" which have been differently understood. The following liberal interpretation by the eminent men above-named, was received and adopted by the Association at its recent meeting in New Orleans, and has met with the approval of the profession generally:

Whereas, Persistent misrepresentations have been and still are being made concerning certain provisions of the Code of Ethics of this Association, by which many in the community, some in the ranks of the profession, are led to believe its provisions exclude persons from professional recognition simply because of difference of opinion or doctrine; therefore be it

Resolved, That Clause 1, Article IV., in the National Code of Medical Ethics, is not to be interpreted as excluding from professional fellowship, on the ground of difference in doctrine or belief, those who in other respects are entitled to be members of the regular medical profession, neither is there any other article or clause in said Code of Ethics that interferes with the exercise of the most perfect liberality of individual opinion and practice.

Resolved, That it constitutes a voluntary disconnection or withdrawal from the medical profession

proper to assume a name indicating to the public a sectarian and exclusive system of practice, or to belong to an association or party antagonistic to the general medical profession.

Resolved, That there is no provision in the National Code of Medical Ethics in any wise inconsistent with the broadest dictates of humanity, and that the article of the Code which relates to consultations cannot be correctly interpreted as interdicting, under any circumstances, the rendering of professional services whenever there is pressing or immediate need of them; on the contrary, to promptly meet the emergencies occasioned by disease or accident, and to give the helping hand of assistance without unnecessary delay is a duty fully enjoined on every member of the profession, both by the letter and spirit of the entire Code, but no such emergencies or circumstances can make it necessary or proper to enter into professional consultation with those who have voluntarily disconnected themselves from the regular medical profession in the manner indicated by the preceding resolution.

MALPRACTICE SUITS.

Two cases for alleged malpractice were tried during the past month in this city. The first was an action to recover \$10,000. The parties were John Johnston, of Midland, and Dr. Kidd, of the same place. On June 21st, 1884, the plaintiff's son, twelve years of age, stepped on a piece of broken glass and wounded the arch of his foot severely. Dr. Kidd was called in, and, as there was no hemorrhage at the time, he stitched up the wound and told the parents to send for him if anything untoward occurred. This they did not do. It bled on several occasions up to the 13th of the following month, but not until then was the doctor sent for. The plaintiff claimed that the doctor did not tie the artery, that the foot was bandaged too lightly, and in consequence mortification set in and part of the foot sloughed away, which will necessitate amputation. After a few of the plaintiff's witnesses were examined, it became evident that there was no cause of action against the doctor, and Mr. Osler, Q.C., who appeared for the plaintiff, threw up his brief.

In the second case the plaintiffs were Jas. H. McQuaig, a farmer in Pickering township, and his

wife, who sought to recover damages from Dr. Eastwood, of Whitby, claiming that in November, 1884, during Mrs. McQuaig's confinement and subsequent illness, he treated her negligently and unskilfully. This trial occupied two days, and a number of witnesses were called on both sides. The principal medical evidence on behalf of the plaintiff was the plaintiff's brother-in-law, Dr. Whiteman, of Shakespeare, supported in part by that of Dr. Warren, of Brooklin. On behalf of the defendant, several medical gentlemen in Toronto were examined, all of whom in the main approved Dr. Eastwood's treatment of the case. The counsel for the plaintiff, Mr. Lount, moved twice during the trial to secure a non-suit, and although the judge ruled against him, he finally charged the jury strongly for the defendant. Notwithstanding the judge's charge, however, the jury brought in a verdict for the plaintiff, assessing the damages at \$350. The case will be appealed.

ONTARIO MEDICAL ASSOCIATION.

The fourth annual meeting of the Ontario Medical Association was held in London on the 3rd and 4th ult., the President, Dr. Worthington, in the chair. There was a large attendance of members present, and upwards of thirty papers on the programme. It therefore became necessary on the second day to divide up into sections, one on medicine and another on surgery and obstetrics. The discussions, both in the general meeting and in the sections, were more than usually varied and interesting. None of the papers were passed over without a satisfactory discussion, and much information of value to the members was elicited. The interest in this young and vigorous Association seems to be increasing yearly. The wisdom of the departure from the former method of preparing reports on medicine, surgery and obstetrics, which were usually taken as read, was well seen in the admirable papers read by the chairmen of the different departments, and the very interesting discussions which followed. We would still further suggest that, inasmuch as it is now necessary to form the Association into sections, that the chairmen of the sections should be elected at the same time as the other officers of the Association, so that the Association may have the benefit of a carefully prepared address in each department at the open-

ing of the sessions. We trust this matter will not be overlooked at the next meeting of the Association. We are also pleased to announce that the next meeting will be held in Toronto. This is, undoubtedly, the most central place in which to hold the meetings. Owing to the numerous railway lines, this city is within easy reach of the greatest number of members, and adding to these the large contingent in the city itself, there is always certain to be a large attendance. Without in any way desiring to speak slightly of the cities in which the last two meetings have been held, we believe that it would be greatly in the interest of the Association if all the meetings were held in Toronto. The choice of Dr. Tye as President of the Association was a well-deserved compliment to an earnest worker and a zealous and worthy member of the Association. The Association has been thus far fortunate in the choice of its leading officers, and so long as such worthy men fill these honorable positions, we can confidently predict for it a grand future.

CANADA MEDICAL ASSOCIATION. — It will be remembered that it was decided at the last meeting of the Association to meet this year in Winnipeg. Owing however to the outbreak in the North-West, and the disturbed state of things generally, our brethren in Winnipeg have reluctantly decided to forego the honor of entertaining the Association this year. In consequence of this decision, and by the kind and pressing invitation of our worthy confrères in Chatham, Ont., the Association will meet there on the 2nd and 3rd of September, under the presidency of Dr. Osler. We confidently bespeak a large attendance, and can promise the members of the Association a right hearty welcome from our friends in Chatham.

CHLORAL HYDRATE IN EPILEPSY.—This valuable remedy is well known to the medical profession, but it may not be so generally known as it ought to be that it is sometimes of invaluable service in arresting epileptic fits, especially that form known as the status epilepticus. We have recently had some experience of its use in a case where all other remedies had failed, including inhalation of ether, chloroform, and amyl nitrite. A twenty grain dose immediately put a stop to the frequently-recurring attacks, and the patient made a good recovery from the seizure.

GENERAL GRANT'S CASE.—Latest reports in regard to the condition of Gen. Grant, would seem to indicate an improvement, but there is no evidence that the case is not hopeless. General Grant is able from his past military experience "to put himself in the place" of his medical attendants to good purpose. His reported remark to his physicians savors of true wisdom: "The doctors outside I am informed, are writing about my case and talking about it, and some of them seem to think they know more about it than you gentlemen do; but it is like a time of war, when the men at home think they know more about it, and how to do it, than the generals who are in the field fighting."

URIC ACID CALCULUS OF ENORMOUS SIZE.—The *Lancet* for May 2nd, 1885, gives the following particulars of one of the most remarkable calculi that the records of surgery furnish. It was removed by the high operation by Sir Henry Thompson, from a man aged sixty-two. The stone was of an oval form, of pure uric acid without any phosphatic incrustation whatever. It weighed 14 oz. avoirdupois (405 grammes), and measured $4\frac{1}{2}$ in. long, $3\frac{1}{4}$ in. wide, and $2\frac{1}{8}$ in. thick. The operation was rapid, and performed without difficulty, and the patient's present condition is unusually good and promising.

PEPTIC SALT.—Dr. Prosser James describes, in the *Brit. Med. Journal* for May 16, 1885, a preparation of pepsin and chloride of sodium, which he calls "peptic salt," to be used as a condiment. The pepsin and salt are combined in such a way as to form a pepto-chloride, which prevents decomposition. He says: It may be ordered in prescriptions, if preferred, as sal-pepticus, or as pepto-chloride of sodium. Ten grains of the peptic salt will dissolve nearly 200 grains of hard boiled albumen, or two ounces of lean cooked meat. It may take the place of table-salt in the dyspeptic's dietary.

NITRITE OF AMYL IN GOUT.—A very important question has been recently raised by Dr. A. McDonald, of Liverpool, in the *Brit. Med. Journal*, regarding the elimination of uric acid by nitrite of amyl. He noticed that on several occasions the acidity of the urine was markedly increased after the administration of nitrite of amyl, and a deposit of uric acid crystals took place in the urine. It

was given in a case of puerperal eclampsia, in gout, and also by way of experiment, and in all the result was the same. The drug was given by inhalation, in four minim doses, every two hours.

BURIED CATGUT SUTURES.—In the *Brit. Med. Jour.*, May 2nd, 1885, will be found a paper by Mr. Kelly in which he advocates "buried sutures" in wounds, that is, suturing separately periosteum to periosteum, muscle to muscle, nerve to nerve, fascia to fascia, skin to skin, etc. The advantages claimed are that drainage is not then required, no spaces or pockets are left where blood or serum can collect, and that cicatrization is rapid, complete and perfect. He refers to a number of operations in all of which he says "the results have been all that sanguine hopes could expect."

WHOOPIING COUGH.—The following has been found of great service in the treatment of this affection, especially to prevent the night spasms.

R	Pot. bromidi	3 j
	Chloral hydrati	℥ ij
	Tr. belladonnæ	3 ss
	Syr. Aurantii	3 j
	Aq. Cinnan	ad 3 iij—M.

SIG.—A teaspoonful at bed time for a child one year old and increase according to age.

USE OF THE MEMBRANES IN LABOR.—In an article in the *Med. Jour. and Examiner*, Dr. Byford of Chicago, makes a strong plea for non-interference with the membranes during labor, or until they protrude through the vulva. The presence of the bag of waters he maintains favors gradual dilatation, serves to protect the parts from laceration, and prevents irregular contraction of the uterus. He regards it as strange that obstetric science should teach the deliberate breaking up of the simple process of nature and substitute an unnatural and artificial one.

MUSTARD SPONGE.—The latest method of applying a mustard poultice is by means of a sponge. The plaster is prepared in the usual way, the sponge is dipped into it, then wrapped in a soft handkerchief, and applied to the part. By simply warming the sponge again and moistening it afresh, it may be reapplied, the strength being perfectly preserved.

LONDON MEDICAL SOCIETY.—The London

Medical Society has been recently reorganized, and the following officers have been elected:—Dr. Beemer, President; Dr. Waugh, Vice-President; Dr. Payne, Secretary - Treasurer. Since the reorganization the attendance has been very good, and some very interesting and instructive papers read and discussed.

APPOINTMENTS.—Dr. Robert L. McDonnell has been appointed physician to the Montreal General Hospital vice Dr. Osler; Drs. Blackader and F. W. Campbell, assistant physicians; Dr. Jas. Bell, assistant surgeon; Dr. W. Gardner, gynecologist, and Dr. Major, laryngologist. Dr. M. McD. Seymour has been appointed surgeon and Dr. F. S. Keele assistant surgeon, of the Winnipeg Battalion of Infantry.

W. R. Warner & Co., of Philadelphia, have received the first premium at the World's Exposition, New Orleans, for great uniformity and solubility for their sugar-coated pills. This is the ninth world's fair prize which attests to their excellence.

The epidemic which has prevailed so extensively in and around Plymouth, Pennsylvania, and which was not at first fully understood, is now said by competent observers to be typhoid fever.

Books and Pamphlets.

THE CURABILITY AND TREATMENT OF PULMONARY PHTHISIS, by S. Jaccoud, Paris. New York: D. Appleton & Co. Toronto: Williamson & Co.

The title of this book is certainly very attractive. The practitioner or student who reads of the curability of intermittent fever by quinine, certain skin affections by arsenic, gout by colchicum, syphilis by mercurials, or hooping-cough by resorcine, may be led to expect that he will find in Jaccoud's treatise on pulmonary phthisis a therapeutic pearl of incalculable value in the control of a malady which has hitherto resisted all the weapons of the pharmaceutical armoury. He will therefore read the book with very sanguine expectations, but when he has reached the end of it he may wonder how it has been that the cures related have fallen very far short of his fond anticipations. We are told that "exceptions prove the rule," but this does not signify that they constitute the rule. That Jaccoud's treatment

of pulmonary phthisis has been, in his hands, *exceptionally* successful, it would be very indecorous to deny; yet when the reader summarizes results, he will most probably find that of the entire category of the cases of this disease, the percentage of cures, even including the shadowy class designated "relative,"—that is, temporary—is mournfully small. The author distinguishes three "varieties of phthisis:—the hereditary, the innate and the acquired form." "Of these," he tells us, "the hereditary form, from the mere fact of its being hereditary, offers the least prospect of recovery." It probably consists with the experience of the majority of practitioners, that this form represents a very large percentage of the whole number, and we fear it has very seldom been the good fortune of any physician to secure the cure of an hereditary case; and if so, the field for the achievement of success must be but limited—far too limited, indeed, to warrant the use of the term "*curability*," unless in a mournfully restricted signification. The term "*innate*," in contraposition with "*hereditary*," seems to us rather inappropriate. Innate literally is equivalent to inborn, ingenerate, inherent, not adventitious. Are not all hereditary diseases such? But it is right to allow the author to speak for himself, which he does in the following words: "Innate phthisis, which must not be confused, as I have already said, with the hereditary form, is observed in the descendants of those who, though not tubercular, are weakened by scrofula, cachectic diabetes, alcoholism, or simply by bad hygienic conditions; besides these causes the innate form may also be due to consanguineous marriages." Now when we shall have added this category of cases to that of the hereditary form, we fear the margin left to curability will be so narrow and shadowy as almost to escape gratifying observance. The author very frankly tells us that we are not to look for great success in this form. "Thus," he writes, "in the innate form there is a possibility, a *chance*, which removes from it the character of absolute incurability, which we were *bound to admit* in hereditary phthisis, when this diathesis was once realised." (The italics are ours.)

Now, as to two, at least, of Jaccoud's factors of innate phthisis,—"*alcoholism*" and "*consanguineous marriages*"—we are very much inclined to doubt their specific efficiency, when they are not allied to hereditary predisposition. Alcoholism,

no doubt, is occasionally the precursor of phthisis, but it is well known that the desire for alcoholic drinks is often the result, not the cause, of the organic evil; besides, the great majority of drunkards die of other diseases; and as to "consanguineous marriages," if the two parties to the contract are of well-established physical soundness their offspring will have a very fair chance of escaping, not alone pulmonary phthisis, but also any other hereditary ailment.

Jaccoud's third variety of phthisis are those, he informs us, "in which the pulmonary tuberculosis, being spontaneous and independent of other diseases, could only be due to general debility, to that insufficient or improper nutrition which is the basis of all forms of phthisis." He calls these cases the first group. He constitutes a second group in which he places "those cases in which the pulmonary disease is connected with a constitutional affection, either past or present, and to the existence of which it may be rationally imputed."

As regards the spontaneity and independence of Jaccoud's "acquired phthisis," we had better defer criticism until more is known of the bacillus of Koch. Still, it would be a pity to bereave the eminent French clinicist of any part of the small residue of that field of "curability" to which his endeavour has reduced his right of possession. His book well deserves attentive study, for it contains much that must be found of real practical value. Had it come from the pen of a less able and eminent author we might have bestowed less notice on it. Youthful practitioners are but too prone to indulge in over sanguine expectations, when they light upon any work bearing the prestige of high authority; and when they realize a succession of practical disappointments, a spirit of medicinal skepticism is likely to be engendered, which may ultimately prove pernicious to themselves and harmful to their patients. Do not give up the ship, but see to your ballast, and do not indulge in studding sails and sky-rakes, in a perilous sea. Be warned by the wrecks of other navigators, rather than learn the dangerous sea line by your own calamitous temerity.

WASTING DISEASES OF INFANCY AND CHILDHOOD, by Eustace Smith, M.D., London. Wood's Library, April, 1885.

This work will be read with pleasure and profit

by every earnest practitioner of medicine. When we consider how large a proportion of all medical practice is presented in the diseases of childhood, we cannot but welcome any valuable contribution to so important a subject. The present issue is a reproduction of the 4th English edition. If we should single out any particular chapter of the book as of paramount value, it would be that one in which the author treats of "inherited syphilis," with which we find but one fault,—its brevity. But it is a *multum in parvo*. General practitioners in this country, but especially those residing in rural districts, may but seldom be confronted by inherited syphilis. This cannot be any reason for their avoidance of its study; rather indeed the very contrary, for exceptional cases are to be met with in all communities, and those to whom they are more familiar well know how puzzling they are, and how eminently important is their clear diagnosis. The practitioner must not deceive himself by expecting frank, much less, spontaneous, information from parents. In nine instances out of ten the soft impeachment will be repudiated, and not seldom disastrously resented—disastrously alike to the doctor and his innocent patient.

THE LAND OF ROBERT BURNS, AND OTHER PEN AND INK PORTRAITS. By J. Campbell, M.D., L.R.C.P., Edin., Seaforth, Ont. Sun Printing Office, Seaforth. Price, 75 cents.

We are glad to welcome this interesting work by our talented friend Dr. Campbell, of Seaforth, which we have perused with much satisfaction. We would especially note the chapter on the defence of Burns, the article on Sir Walter Scott, and also the reference to Knox and the Covenanters. The work consists in a series of letters written to the Seaforth *Sun* during a holiday trip to Scotland, a few years ago. These are now collected in the volume before us, to which has been added the valedictory address, delivered by the author on his graduation in McGill College, in 1869. The work is both pleasing and instructive, and cannot fail to interest a large number of readers. We congratulate our worthy confrère upon his success in the literary arena, and trust that the work will meet with a large sale.

ON MALIGNANT ENDOCARDITIS.—The Gulstonian Lectures delivered at the Royal College of Physicians, London, by Wm. Osler, M.D., M.R.C.P., Prof. Clin. Medicine, University of Pennsylvania. Reprinted from the *Medical News*. Philadelphia: Lea Bros. & Co.

A HAND-BOOK OF PATHOLOGICAL ANATOMY AND HISTOLOGY, by Francis Delafield, M.D., and T. Mitchell Prudden, M.D., of New York. Second edition. New York : Wm. Wood & Co.

The scope of the work in the present edition has been much extended and will be found to supply all the needs of the student or practitioner. It comprises instruction in the methods of making post mortem examinations, preparing tissues for microscopical examination, examining bacteria, etc. It contains a description of tumors, and also lesions in different parts of the body the result of disease, violence, or poisoning, and the like. The text is well illustrated, and the work on the whole one to be highly commended, and a valuable addition to the literature of the subject.

THE PRINCIPLES AND PRACTICE OF GYNÆCOLOGY, by Thos. Addis Emmet, M.D., LL.D., Surgeon to the Woman's Hospital, New York. Third edition. Philadelphia : H. C. Lea's Son & Co. Toronto : Williamson & Co.

The edition of this most excellent work now before us has been thoroughly revised by the author, and is illustrated by one hundred and fifty illustrations. The work is essentially a clinical digest, and includes the results of the author's experience. It also aims to represent the present state of gynæcological science and art. The author does not favor intra-uterine medication, and regards the different forms of pelvic inflammation outside of the uterus as constituting the chief factor in the diseases of women. The book is a welcome addition to the literature on this interesting and important branch of medicine.

AMPUTATIONS OF THE EXTREMITIES AND THEIR COMPLICATIONS, by B. A. Watson, A.M., M.D., Surgeon to the Jersey City Hospital. Illustrated by 200 engravings. Philadelphia : P. Blakiston, Son & Co. Toronto : Hart & Co.

The author of this new work is a thorough disciple of Lister, to whom the book is dedicated. The scope of the work is much broader than might be inferred from the title, inasmuch as the author deals with all possible complications of amputation wounds. A number of original wood-cuts have been introduced, but the majority are selected from the standard works on surgery, etc., both home and foreign. One important subject is treated of which is rarely found in surgical works, viz., the formation of desirable stumps for prothetic apparatus, the

point at which amputation ought to be made, and the selection and application of artificial limbs. We commend the work to the attention of our readers.

A MANUAL OF THE PRACTICE OF SURGERY, by Thos. Bryant, F.R.C.S. Eng., Surgeon and Lecturer on Surgery at Guy's Hospital, with 727 illustrations. Fourth edition. Philadelphia : Lea Bros. & Co. Toronto : Williamson & Co.

The two volumes of the English edition have been consolidated into one in the American reprint. This makes the work much more convenient for reference. As it has been recently revised by the author, it has been reprinted without any alteration. No words are needed from us in praise of the work, for both it and the author are favorably known to the profession in this country. The work fully and fairly represents the present status of British surgery, and as such we commend it to the attention of our readers.

A TREATISE ON THE SCIENCE AND PRACTICE OF MIDWIFERY, by W. S. Playfair, M.D., F.R.C.P., Prof. of Obstetrics in King's College, London. Fourth American from the fifth English edition, with notes and additions by R. P. Harris, M.D., with two plates and 200 illustrations. Philadelphia : Lea Bros. & Co. Toronto : Vannevar & Co.

This work is already well known to the profession as an excellent epitome of the science and practice of midwifery, and we gladly welcome the new edition. The work has undergone a careful revision at the hands of the author and his assistants, and the chapter on Conception and Generation has been re-written, so as to incorporate the most recent advances in Embryology. Several new illustrations have been added, and the work will be found a trustworthy guide in the anxieties and emergencies of obstetric practice.

Births, Marriages and Deaths.

In Montreal on the 1st ult., Dr. P. E. Picault aged 76 years. Also Dr. Jos. Leman, aged 56 years.

In Kingston on the 19th ult., Tina Laura Stirling, beloved wife of Dr. K. N. Fenwick, aged 26 years.

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Original Communications.

DIPHTHERIA.*

BY G. A. TYE, M.D., CHATHAM, ONT.

No subject can be presented to practical physicians that possesses a greater interest than diphtheria—a disease as ancient as history itself, and as widely spread as the human race. It stays not its ravages for country nor climate; it ruthlessly invades alike the hut of the peasant and the palace of the prince; it is not ashamed to claim its victims in the house of poverty, nor fears to enter the home of luxury. Many here to-day have had the circle of their own fireside broken, and every one here has felt his utter weakness when the home of his friends was desolated in spite of all his art, and to-day we unite our forces to meet a common foe.

We possess two means—*prevention and cure*—which enable us to lessen its ravages. Our greatest power at present lies in the former. It is a great satisfaction that at last we have a system of State medicine established in Ontario, and that legislative enactments now guard the birthright of every subject's health. Such legislation marks an advance in true civilization. The country owes much to the Ontario Board of Health for its energy, intelligence, and thoroughness in carrying out the Act. The people of Ontario are being rapidly educated in sanitary matters, and there are fair prospects that the prevalence of this disease, as well as many others, will be soon limited.

The report of the Registrar-General shows that it ranks high amongst the fatal diseases of this Province. For the year 1876 he reports a large increase in the number of deaths. In 1874 the deaths were not sufficiently numerous to be placed in the list of the ten highest causes of death, but in 1876 it stands third. Many deaths really due

to diphtheria are returned as croup; but the death rate from croup also increased in the same year, showing that they were probably due to one cause. In 1877 it stood fifth; 1878, fourth; 1879, sixth; 1880, fifth; 1881, fourth; 1882, fifth, in which year there were 1,239 deaths from this cause alone.

The predisposing causes are telluric, meteorological and individual. Amongst the former are low, damp situations. Houses are placed close to the ground, with no provision for currents of air to pass beneath them to dry the soil or expel noxious vapours. Houses too closely surrounded with plants, shrubbery, or trees, are favourable to the development of low organisms. River flats, sites of old saw mills where there is much decomposing sawdust, seem to be prejudicial. I have observed several cases apparently due to these causes—at least no other could be found. I have notes of nine cases observed in the autumn of 1884, which occurred within two weeks in two adjoining blocks of small tenement houses, placed close upon the flat, damp, undrained ground. Dr. Ryall, Medical Health Officer of Hamilton, reports to the Board of Health (in April last) of that city, the condition of the premises in which diphtheria was found. The description is so vivid and terse that I produce it: "The results of the examination of the affected districts revealed cellars dirty and damp, smelling strongly of sewer gas, vegetables stored in cellars decomposing and smelling badly, kitchen sinks and baths untrapped and unventilated, being connected either with sewer or water-closet, or bad smells in back yards, defective pan water-closets, soft-water cisterns under the kitchen floor, well-water used which received drainage from the surface manure heaps. A few cases occurred where the premises were in good order, but the surroundings were bad." The germ of diphtheria, whatever that may be, always finds in such conditions a suitable nidus for development—breeding spots where one germ generates many. All these causes are in the preventible list, and with the aid of the physician the people can remove them.

Meteorological conditions of a certain kind are strongly predisposing. The Michigan State Board of Health finds that diphtheria is increased by—increased daily temperature above the average for that period of the year, increase of humidity, increase of cloudiness, excess of winds, excess of ozone, high barometric pressure. Our own health

*Read before Ont. Med. Association, London, June, 1885.

reports establish the fact that the disease is most prevalent in November and December, when many of these conditions exist. During this period there are high barometric pressure, magnetic displays, and an electrical condition of the air producing nascent oxygen and ozone. The experiments of B. W. Richardson show that these gases are irritating to the respiratory passages, hence we find an excess in sore throats, and a corresponding increase in diphtheria. We must conclude from these premises that sore throat is a favourable locality for the reception of the diphtheria germ. The throats of children are very susceptible to atmospheric changes, and consequently age is a predisposing cause. The greatest mortality occurs from two to five years of age. The Registrar-General's Report for 1879 states that, of 574 deaths, 283—or about one-half—were under five years; 184 between five and ten. In 1881, 72 per cent. were under sixteen; in 1882 there were 1,239 deaths, 83 per cent. were under fifteen. The *exciting* cause of this disease is probably a germ from some former case. Bacterial pathology has not yet clearly established its nature. The natural history of these germs teaches us that they thrive best where there is moisture and decomposition of organic matter, and continue to produce their kind so long as favorable soil is present, and that those already formed may linger long in a locality after the production has ceased.

Dr. Bryce in the Health Report for Ontario, says there does not appear in the whole catalogue of disease one which is so persistently endemic in a locality when once introduced. What are the modes of communication? It is communicated by the direct passage of morbid material from a diseased throat to one previously healthy. The history of tracheotomy presents some lamentable illustrations of this fact. It may be communicated by the inhalation of germs existing in an insanitary locality, although no case of the disease then exists there. It is communicated by germs wafted in the air, and that for a considerable distance; and they produce the disease, more especially when a predisposition exists, so that many suffer whose sanitary surroundings are apparently perfect. The clean, as well as the unclean, may be obliged to share the calamity. I shall confirm these propositions by a few cases. A medical man reports to the Provincial Board that the mother of a large

family laid out the body of a little girl dead of diphtheria. In a few days four of her children were down with it. The pall-bearers were boys. One of them took it home, and seven of that family were taken ill.

Last December I saw a boy, aged fourteen, then ill for five days. His mother saw membrane in the throat. Croupy symptoms were strongly marked. It was a serious case. I found that three weeks previously he passed the night at the house of an uncle, and slept in a bed in which a child had recently died of diphtheria. Dr. Holmes, of Chatham, related a case which seems to show that it may be carried in clothing. A gentleman called at a house on business, and was obliged to remain there some hours. The disease existed in this house. He went to his own home some miles distant. No cases were near his own residence, yet both wife and child took the disease, and the child died.

Dr. Mullin, of Hamilton, tells of a family under his care; four members suffered; the first a school-boy; the early indications appeared Nov. 6; the other children were sent from home at once, and the patient was convalescent on the 13th. The other children were brought home on the 20th, and efforts made to keep the convalescent one isolated; however, on the 30th another was seized; Dec. 1st another, and on the 6th the third. He says the occurrence in the last three seems to him fairly attributable to contagion from the first.

During the winter of 1884, I observed a number of cases in one neighbourhood, which seemed to prove its passage in the air. In a tenement house, standing alone in a filthy state, two children died of diphtheria; across the street, and a few rods eastward, was a row of houses, all situated on high, dry ground, fair water and families in good circumstances. In a few weeks after the deaths in the tenement house, it appeared in this row, which was in the direct course of prevalent winds; two children in one house, five in the next, and four cases in the third house, in all 11 cases occurred in this row of houses; the two in the first house recovered; one of the five in the second house died of heart paralysis some days after apparent convalescence, another had a narrow escape; in the third house one died; a visitor had contracted tonsillitis while boating on a damp evening; she died from stenosis of the larynx. Four weeks later five cases oc-

curred in an adjoining block, in my care ; another case close by attended by another physician ; some weeks later, in a house close to the original outbreak, but on an opposite side, two children died in one family, altogether 19 cases and 6 deaths in a radius of about 20 rods. Our Board of Health was not yet organized ; had there been means to have thoroughly cleansed house No. 1, I believe disease and death would have been prevented.

Prophylaxis is a most essential part of the treatment, for more can be saved by prevention than by cure. It must be confessed that our treatment is not yet what we may hope for. The prophylactic measures can be inferred from the etiology already stated. Let the unaffected ones of a family be isolated at once, if possible, in another house, and in a different locality, as high and dry as can be secured, and let the quarantine be prolonged. All exposure to cold winds must be avoided. Keep throats of sound children disinfected with proper applications. I am sure this will prevent some cases. Every case of sore throat should be promptly treated. Rooms occupied should be large, well ventilated, and kept at an even temperature. The vapour of turpentine, tar, or sulphurous acid are probably useful, and are very well tolerated. Every infected locality should be visited by the authorities and completely disinfected to prevent the spread of the disease.

The question of the identity of croup and diphtheria has been discussed for some time without reaching a definite conclusion. The views of Lewis Smith in a recent article are correct, that membranous croup is not a disease of itself, but an outcome of other diseases or conditions, and states them in the order of frequency : 1. diphtheria ; 2. cold ; 3. measles ; 4. pertussis ; 5. scarlatina ; 6. typhoid ; 7. irritating inhalations. He says that in all instances the morbid anatomy, clinical history and required treatment of the croupy state are nearly identical ; and that attempts to differentiate them are futile. This puts the identity as regards treatment too strong, for in diphtheritic croup the system's condition is more adynamic than in croup from cold. In croup from other causes there is a sthenic condition, stenosis is the principal difficulty, and calomel can be pushed farther or jaborandi used.

Jaborandi was tried extensively in the terrible epidemic of diphtheria in Russia a few years ago

in the croup cases, upon the theory that the abundant secretion produced would so influence the condition of the parts as to prevent the formation of membrane or dislodge that already formed. The statistics do not favour its use in diphtheritic croup from its depressing tendencies. In cases of croup due to cold I have found it a powerful agent for good, and children tolerate this drug to a remarkable degree.

The *treatment* of this disease has a superlative interest. It is strange how many specifics there are—how many there are that find sure cures and safe cures. There are medical men who say they have never lost a case. Happy is the man who can so flatter himself. The local treatment is secondary in importance to the general treatment. The throat is now no longer injured by caustics, acids and rough swabs, which would produce a sore throat where none already existed. The throat should be kept as clean as possible with frequent gargles of hot water, which lessens the hyperæmia. Solutions of chlorate of potash are grateful. A soft camel's hair brush should always be used to make applications. There are many applications so equally good that it makes little difference which we employ. Sulphurous acid and glycerine, with the addition of thymol, is effectual and pleasant. Oil of eucalyptus and liquid petroleum make another good topical remedy. Lactic or acetic acid with glycerine I have found useful. The atomizer is an excellent instrument to make applications to the throat by the mouth, or through the nose, where the patient's age permits. Much harm can be done by using violence to dress the throat. Solutions that permit of being swallowed are better than forcible swabbings. Formerly membranes were eagerly detached, leaving a raw, bloody surface, upon which a new membrane rapidly forms, often in 24 hours. The membranes should be well cleansed and disinfected, and allowed to drop off when ripe for separation, after which they rarely return. Loose, hanging portions can be removed with scissors. Rossback, of Germany, after four years' trial, speaks favorably of the vegetable digestive papayotin. It acts well in an acid or an alkaline medicine. Dr. Lewis Smith mixes one drachm of Fairchild's extractum pancreatis with three of sod. bicarb, then adds one teaspoonful of this to six of water and pencils the fauces, and uses trypsin with the atomizer for mem-

branes in the larynx. A discussion of this subject at the last meeting of the American Medical Association confirmed the use of tried remedies, but nothing new of value was introduced.

The longer I treat diphtheria the more am I convinced of the power of tincture of iron, alcohol, quinine, and chlorate of potash, but the first mentioned is superior to all. These articles are all eminently safe, whether the tendency to death be from asthenia or from asphyxia; but the best effects of iron are seen only when administered in very large doses. Dr. Jacobi, in the *American System of Medicine*, recommends from 5 to 15 minims properly diluted every fifteen minutes or half hour, and I am sure from my own experience that this is valuable teaching. There is certainly a tolerance of the drug in this disease.

Alcohol given early and freely stands next to iron. Austin Flint, in an admirable article on Medicinal and non-Medicinal Therapeutics, thus speaks of alcohol in this and kindred affections: If alcohol be useful as a material for combustion within the body, it is indicated in the condition of fever, prior to the indication for its employment to sustain the failing powers of life. The object from this point of view is to forestall these indications and prevent the asthenia. It is evident that employed with a view to test fairly its value as an antiseptic or parasiticide, or as an antidote, it is important that it should be employed early, continuously, and in as large quantities as it may be tolerated.

Chlorate of potash is a well established remedy, but given in very large quantities will produce nephritis and albuminuria. Quinine in tonic doses is an excellent adjunct, but its bitter taste makes it difficult to administer to young children. When croupy symptoms appear there is still a possibility of arresting the further progress of the membrane by the increased dose of iron and alcohol. For many years I have found excellent results from the frequent administration of small doses of calomel, one gr. per hour, and free inunction of the neck with oleate of mercury. I know no remedy equally potent. The inhalation of moisture, in the form of vapour, is beyond doubt of considerable value. The atomizer is the best instrument for producing the vapour. I have tried to use ice, but my patients would never tolerate it long enough to judge of its merits.

When the stenosis continues to increase in spite of remedies, no time must be lost if the trachea is to be opened; for if there be any hope from the operation it is when done comparatively early. The results are not encouraging. The benefit of this operation, so manifest in croup from other causes, is not found in diphtheria, for it does not check the disease. Dr. Holmes, of Chatham, informs me that he has operated three times with a fatal issue in every case, but he would advocate the operation for euthanasia.

The albumen of this disease is rarely due to a nephritis, but to congestion of the kidneys, for it rarely produces dropsy or uræmia, and recovery is rapid after the cessation of the cause. The dyspnoea produces general engorgement which the kidneys must share; or the vagus being effected, the heart is weakened, and the congestion is due to this cause. The paralysis of diphtheria is fortunately not very frequent; some epidemics are much more marked than others by its appearance, and unless it involves the heart, or the paralysis is general, there is a strong tendency to spontaneous recovery. I have used faradism, but cannot say that it has hastened recovery. There is some evidence that galvanism has a beneficial influence. Professor Thacher, of Yale, has made some careful observations on the effects of massage, faradism and galvanism. There was a positive gain from galvanism, no effect from faradism, while massage seemed to lessen the power.

PLASTER SPLINTS IN THE TREATMENT OF FRACTURES.*

BY N. A. POWELL, M.D., EDGAR, ONT.

MR. PRESIDENT,—When, a year ago, I proposed that instead of the annual reports containing digests of the progress in each department of medical science, such as had been presented to you, discussion should be arranged for, I did so with the conviction that the existing facilities for the rapid transmission of medical events to every reading member of the profession render such reports no longer necessary. In offering a resolution which you saw fit to adopt, I had no thought that like Haman of old I should be the first to appear on the gallows which I had moved to erect for another.

*Read before the Ontario Med. Association, June, 1885.

However, being here, in hope that the interest attached to the subject may redeem my faulty presentation of it, I ask your attention to the use of plaster splints and bandages in the treatment of fracture. Of all the materials which may be used to form dressings, soft when applied but rapidly becoming hard and unyielding, this is the best and the best is just good enough till we can improve upon it. Plaster of Paris or gypsum, used in surgical practice by the Arabs in the last century is perhaps not better than when first introduced, but the methods of its use have undergone a process of evolution and are now so perfect as to merit the close attention of each one of us. A clear distinction must be made between such splints, and bandages. By the first we mean supports moulded to a part only of the circumference of a limb or other portion of the body, while by the last we mean dressings which completely encircle the extremity requiring fixation. The two forms of course may approach each other till they meet and merge. As a class the splints are removable at will while the bandages are not so. This distinction is important since the risks belong almost entirely to the bandages, while the benefits can as a rule be obtained by one form or another of plastic splints. Believing that in regard to comfort and security from displacement they are, in the treatment of certain selected fractures better than any other means at our command, I have raised the question of their use in the hope that through you, and with your aid, it may be possible to reach and impress a number of our brethren who either do not use these appliances at all, or do not use them in ways most convenient for themselves and most helpful to their patients. It is to be expected that the discussion evoked will be of greater value than the paper read, since it will become the means of recording a wider experience and reflecting the ideas of others from different standpoints. Let me remind you that your indication of points upon which we differ may be productive of more good than a silent reception of whatever is advanced. With the object of economizing time I shall spare you historical details, shall speak perhaps somewhat dogmatically, and shall give you conclusions rather than the reasons which have led me to them. I shall seek less for originality than for practical utility, and whether speaking or listening shall not forget the saying of Paget, that each one of us has some-

thing which he may teach, and much more which he may learn. If upon some points I enter into detail, it will be because of a belief that in attention to these minor matters lies all the difference between danger and safety, between success and failure. I base what I have to say on what I learned as a student from my old and honored teacher Dr. F. H. Hamilton, of N.Y., on ten years constant use of gypsum dressings, on such study as I have been able to give to the literature of the subject, and on what I have from time to time seen in the hospitals of New York, Boston, and Philadelphia. I trust that some who hear me and who have had trans-Atlantic experience will give us the results of their more extended observation.

Materials—Only the finest and freshest dental plaster should be used. The common sort applied as a hard-finishing by plasterers is not fit for surgical purposes and its use invites failure. The office supply should be kept in tins the covers of which screw down air tight upon rubber rings. Cosmoline tins, of five lbs. size, may be obtained at any drug store and answer the purpose perfectly. In preparing the mixture of plaster and water known as "cream" the solid should be added to the fluid and not the fluid to the solid. About an equal bulk of each makes the proper proportion. Common salt or the sulphates of soda or potassium or alum can be added to the water to hasten the setting of the plaster, while a weak solution of glue or gelatine, if used, would delay such crystallization. Cloth sufficiently porous to allow the plaster to set in its meshes and not simply on its surface is the other essential. The experiments of Drs. Marcy and Nelson proved that the lightest and strongest of plaster dressings were those made from cotton cloth such as is used for printing upon. This, free from fatty matters or starch finish is only to be obtained from the bleacheries. It differs from cheese cloth as cotton batting differs from absorbent cotton. Cylinders made with it and plaster, crushed down only at a pressure of 110 lbs. while those of equal weight and thickness made from crinoline crushed at 60 lbs., and from cheese cloth at 10 lbs. Acting on this hint I have been in the habit of using cheese cloth for plaster bandages, first preparing it by boiling in an alkaline solution and then in clear water to remove the alkali. I am satisfied that the gain in strength is sufficient to pay for the trouble, but regret that I cannot as yet

make a more accurate statement. The size to be preferred is a width of three inches and a length of three yards. Into the meshes of such bandage material the plaster is to be rubbed by hand, and then each roller is to be wrapped in paper if it is not to be used at once. They can be best kept in the tins covered by a layer of plaster. From unsized cheese cloth, from bleached Canton flannel, from cheap, that is cotton-containing flannel, or from old blanket, all other plaster dressings may be made. As a protection for osseous prominences and as a lining generally for plastic dressings, unbroken rolls of the finest cotton batting, white cotton wadding in roller form or blanket flannel will be required. A solution of the bicarbonate of soda in water or the white of an egg will remove the unpleasant feeling left in the hands after using plaster.

Methods—Upon the principles of the treatment of fractures there is general agreement, but on no subject in surgery do opinions differ more widely than upon the methods by which these should be carried out. In part this is due to the fact that similar good results may be obtained by so great a variety of means. The particular plan employed is of much less importance than the skill and judgment used in its application. A surgeon with strips of wood, padded with moss, and secured by thongs of basswood bark, will succeed, where a mal-adroit backed by a brigade of surgical machinists will fail. Progress of late has been in the direction of simplicity with efficiency, and these are marked characteristics of plaster dressings. The material affords scope for the ingenuity and dexterity of the ablest of surgeons, while on the other hand it may be used in safe and simple ways by any one who will take the trouble to master the *technique* of such dressings. Not to every one is given the ability to invent modifications, as special cases require them, but good methods and correct models are not hard to follow. The plans we shall consider are not the results of any one man's work. Many have labored and we enter into their labors, since that which is of value the profession retains and develops. We may justly claim that

"All of good the past hath had
Remains to make our own time glad."

The spiral bandage with plaster in its meshes applied over a leg fracture may be taken as a type of all the uses of the roller. I shall describe some-

what minutely what I hold to be the best manner of its application. The limb, if hairy, is to be oiled, and then it is to be enveloped in a thick layer of cotton batting taken unbroken from a roll. This layer should extend from the toes to the mid-thigh, should meet in the middle line in front and should be held in position by thread wound around the leg. Over this is to be applied with moderate firmness by the figure of 8 turn, and without reverses, a dry cotton roller. This must not be confounded with that relict of the dark ages a "primary bandage." The gauze cloth or crinoline bandages before described are to be next placed two at a time on end in a bowl of warm water. When the bubbles cease to escape they are taken out pressed to expel surplus water, and are applied from the toes up. No one turn should be drawn more snugly than another. If too tight there is danger of strangulation, while if too loose the risk is that co-aptation of the fragments will not be maintained. Each layer as applied should be well rubbed by the hand to expel the air between it and the one next beneath it. From three to six layers will be required. An assistant is to make moderate extension during the application, and for from ten to thirty minutes afterwards. The heel should rest in his right palm, while his left hand is passed around the instep. If seated comfortably, and able to rest his forearm against his knees he will be able to hold the foot at right angles with the limb, prevent rotary displacement by sighting over the great toe and inner margin of the patella and will not become unsteady through muscular fatigue. To bring the toes up after the dressing is completed is dangerous, since it is apt to constrict at the instep. To allow them to drop is to run the risk of having the heel permanently elevated. When the limb is a heavy one, an inch wide stiffener of perforated tin may with advantage be interwoven in the bandage at each side. When the shell has become fairly firm the limb is to be placed upon a moulded pillow on which in from two to four hours it will become sufficiently rigid to stand being suspended. Such an apparel, light, shapely and perfectly fulfilling the indications, is the one I ordinarily employ in the *later* stages of leg fractures. It gives a firmer support than any hinged splint, and its use will materially shorten the period of confinement to bed. An elevated shoe on the sound side will assist the patient to keep the promise exacted from him that

he will not, till allowed, bear weight on the injured limb while moving about on crutches.

In recent fracture I much prefer an apparel that will allow examination from day to day till the consolidation is well advanced. Even after the most perfect reduction I want to *know* and not simply to *hope* that the fragments maintain their proper position, and that the soft parts over them are in good condition. In 1872 I first applied what is known as the Bavarian or book splint. After using it a few times I began to substitute shaped pieces of cheese-cloth saturated in plaster cream and placed between the inner and outer flannels, for the thick usual layer of solid plaster. With this hinged splint I have treated about thirty fractures of the bones of the leg. It is lighter and stronger than the Bavarian, as ordinarily made, and it can be applied with safety when to use a plaster bandage would be malpractice. By placing the limb first on one side and then on the other the halves of the splint can be raised like lids, and the seat of injury examined without risking in the least a disturbance of the process of repair. I show you one of these, but shall not urge its claims upon you since I wish to use the time at my disposal in advocating a still better and more easily applied retentive apparatus. This is one that I first saw at the Boston City Hospital three years ago. It is known as the "plaster posterior splint," and its development is largely due to the skill and ingenuity of Dr. R. A. Kingman, of Boston. This gentleman writes me that the original idea came from Brooklyn, N.Y., and that his connection with it has been in improving its details and demonstrating its utility and practicability. Through his courtesy I am able to show you three photographs of one of these as applied before the Massachusetts Medical Society last year, after the reading of a paper on the subject by Dr. Geo. W. Gay, surgeon to the City Hospital. I show you also a completed splint and a pattern of the shape into which the material for it was cut. One surgeon, well able to judge, considers this to be the most important advance in the treatment of leg fractures within the last fifty years. Another, and with him I certainly agree, thinks that it comes nearer than any other to being an ideal dressing for a broken leg. Unlike the Bavarian it is always open, permitting sufficient examination without disturbing the limb. It is also far easier to apply, and when applied is self-retaining. It

may be made in this way: The limb is first bandaged with wadding in roller form, enough being used to protect the bony processes and the tendo-achilles from pressure. A single layer of gauze or crinoline large enough to extend from the toes to above the knee, is to be placed beneath the limb closely wrapped about it and cut so as to completely surround it with the exception of a space about an inch wide on the anterior aspect. This piece serves as a pattern by which the other layers, six or eight in all, are cut. The cloth is to be deeply slashed on each side opposite the point of the heel to allow the foot piece to be brought to



Pattern of "Plaster Posterior Splint."

a right angle without forming clumsy folds. The layers are now to be soaked in plaster cream, placed one upon another, applied to the limb at once and moulded closely and carefully to it. At the sides of the ankle where the angles from the foot piece and the leg piece overlap, I find it gives the neatest result if they are interlocked two at a time. A bandage rapidly applied secures a perfect fit of the splint to the limb and can be removed when the plaster has become firmly set. If no bandage be left on the leg the splint will accommodate itself to

any reasonable amount of swelling. Some cases of Pott's fracture with marked eversion of the foot require more powerful pressure to maintain reduction than this appliance can give. For the cases however to the treatment of which it is adapted it will be found a comfortable and efficient, as well as a light, safe and æsthetic dressing. While I would hesitate to advise the adoption of the spiral bandage as a routine dressing for recent fractures, I feel free to say that its advantages can be secured and its risks avoided by the use of the splint just described. Swelling may not, and in the vast majority of cases will not occur if this be early applied. Such swelling is no more a necessary accompaniment of the repair of a fracture than of the healing of a strictly aseptic wound.

For what fractures is the treatment by gypsum to be recommended?—For those of the lower jaw, in which an inter-dental splint either is not required or is not obtainable. Six layers of cheese-cloth (or two of Canton flannel) cut to the proper size and shape, soaked in plaster cream, moulded to the part, coated when hard with spirit varnish to afford protection from saliva and lined with cotton or Canton flannel, will make an appliance as serviceable as any other. A Barton's bandage will retain it in position. I show you one made in this way. A broken clavicle can be treated in half a score of ways, any one of which would fulfil the indications as well as any application of plaster of Paris with which I am acquainted. The humerus broken in any part may be safely and securely retained with its fragments in normal position by shoulder caps, internal angular splints or some combination of these made rigid by plaster. The internal angular splint is also, in my opinion, the best for fractures at or near the elbow. I show you outlines of the shapes into which cloth may be cut to form these supports, and also have here completed splints. The angular ones have no special advantage over those of similar shape which may be made from softened binders-board. No single fracture of the forearm is as well treated by plaster as by properly padded wooden splints. A plaster bandage seems to me to be the worst of all dressings for those which occur near the carpal end of the radius. It tends to press the bones together and to obliterate or narrow the intervening space. It prevents the frequent examinations so requisite here. It constricts a part which being dependant

is apt to swell and it has not even the excuse of adding to the patient's comfort. Just here let me protest against the dangerous doctrine that all may be considered to be progressing favorably if only the fracture gives no pain. The worst results I have ever seen have come from an acceptance of it by those who are using plaster in an unskilled manner. The problem presented by a Colles' fracture is best solved by, first, a perfect reduction and, second, the accurate pressure of a dorsal pad over the lower fragment and a palmar pad over the lower end of the upper one. Such correctly limited pressure is what we cannot get with a plaster bandage, and so I condemn its use here. Under exceptional circumstances a plaster jacket might be advisable over broken ribs, but unilateral strapping with imbricated strips of good moleskin plaster has sufficed in all the cases which I have so far seen. A recent fracture of a thigh bone may be put up by experts in a hospital, where from hour to hour it will be under observation, but under other circumstances this method is not to be commended. The dangers are greater and the results are not proven to be better than by the alternative plans. Drs. St. John, Marcy, Cowling, and Sayre, have urged the adoption of the plaster bandage as a routine dressing for these lesions, but the vast majority of those who, like myself, have fairly and without prejudice tested the plan, have given it up in favor of the two others which have a right to our entire confidence. These are Buck's modification of the weight and pulley extension of Hildamers, and the Smith-Hodgens' oblique suspension. A surgeon at the present day who has had shortening or deformity after a thigh fracture to account for to a jury, will be less likely to be mulcted in damages if he can prove that with intelligent and conscientious care he has used one of the above plans, than if he has put his trust and his patient's limb in plaster, or as Rip Van Winkle might, has depended on the long splint of Lister.

My conviction is that continuous and equable extension, indispensable here, is not maintained by the most perfectly applied plaster bandage, still less by any plaster splint. After fairly firm consolidation I do not object to this form of support, although by it I have seen a knee so stiffened that its patella was fractured in the attempt to regain motion by *Brisment forcé*.

Taking up next the patella I shall only state my

entire approval of the splint made according to the method of the late Dr. J. L. Little, of New York. The oblique strips to fix the patellar fragments, hardening while the fingers of the surgeon hold the parts in apposition, are better than adhesive plaster or anything else of which I have knowledge. Dr. Little's paper can be found in the *Medical News*, March 29th, 1884. With few exceptions fractures occurring below the knee are better treated by plaster than in any other way whatever! A fracture box, filled with oakum, may be used for a few days if swelling is extensive. If not, a hinged or posterior splint, as described, should be applied, and the limb at once suspended. Any blacksmith can make, for a few dollars, a Salter's cradle, which put together with thumb-nuts is very portable. In mine the limb is supported on strips of bandage, exactly as in Hodgen's thigh splint. The saddle pad required to prevent very oblique fractures of the tibia from becoming compound, or used for the same purpose in connection with the V or Y shaped fractures of the tibia, so well described by Gossulur, can be well applied if a posterior splint has been reinforced by three strips of tin in its substance. Time does not obtain for my discussing at any length the subject of compound fractures, yet it is just in this class that plaster dressings have given the most brilliant results. Fenestrated or bracketed plaster bandages, and antiseptic occlusive or "through drainage" methods have changed the prognosis in these injuries, lessening the number of cases that demand amputation, and reducing to a minimum the septic dangers that are to be feared in an attempt to save the limb.

What risks attend their use? These depend on the selection of unsuitable cases, an improper application of the dressings, or an improper management after application. No solidifying dressing should ever be applied to a recently broken limb if much contusion, swelling or ecchymosis exists, or if there is doubt as to the integrity of the deep vessels of the limb. The toes or fingers should always be left uncovered, and should be watched so that on the least evidence of sluggish circulation the encasing material may be cut down or otherwise loosened. Circular compression and strangulation are most to be dreaded. A plaster case may look well and yet be the cause of deadly danger. It cannot be denied that the bad results following the plan of treatment we are discussing are

out of all proportion to the number of cases treated by it. Too frequently the usefulness of the limb and the reputation of the surgeon have been involved in a common ruin. Its intemperate and indiscriminating advocacy by certain men who ride their hobbies with whip and spur, have led to its employment by those not practically familiar with it, and too indolent or careless to become so. Dr. Coskery, for instance, at the last meeting of the Med. and Chir. Soc. of Maryland, stated that "it was highly improper to keep a patient suffering from a simple fracture of the thigh, on his back even for 48 hours. Such treatment would be a justifiable cause for a suit for malpractice. Dr. Sayre in a private letter read at the meeting of the Georgia State Medical Society in '84, said, "I dress *all* fractures simple, compound, comminuted and complicated, immediately after the accident if I can see them before the swelling has occurred . . . and a perfect recovery without deformity is the rule instead of the exception as was formerly the case." Dr. Sayre's statistics, as most of us know, are being constantly, though perhaps unconsciously, moulded to fit his theories. Like a good microscopist, he *can* see anything that he *wants* to see, but it is only just to him to say that he really *does* see more that is commonly overlooked than any other surgeon with whom I have the honor of an acquaintance.

Advantages claimed :

1. The fit being perfect there is little liability to displacement.
2. Support sufficiently firm to prevent displacement is obtained before even the busiest practitioner has to leave his patient. This is not the case with any similar plastic material.
3. Compression is uniform; limiting extravasation and controlling muscular movements.
4. In some form these dressings can almost always be applied at the first visit.
5. The material is always at hand and costs almost nothing.
6. Apparatus made from it can be depended upon not to contract in drying, as those made from other plaster materials do.
7. They are sufficiently porous to permit the escape of the perspiration.

DR. OLIVER WENDELL HOLMES says that a doctor's patients must put their tongues out, and a doctor's wife must keep her tongue in.

RENAL CALCULI.*

BY A. GROVES, M.D., FERGUS, ONT.

In the comparatively brief time allotted to readers of papers before this Association, I propose to discuss the subject of renal calculus, first as to its causes and then briefly indicate the line of treatment I have found most beneficial in my own practice. In order to show that the subject is one of great importance and well worthy the serious consideration of all members of the medical profession, it is only necessary to recollect that forty-seven per cent. of all infants whose kidneys have been examined were found, according to Ebstein, to present evidences of uric acid infarctions, and it is also a well known fact that more than ninety per cent. of all cases of stone in the bladder have originated in a small concretion that had passed down from the kidney.

Several theories have been advanced to account for the formation of renal calculi, such as the catarrhal, the gouty, the diathetic, etc. By those who believe in the purely diathetic origin of calculi it has been argued that there are three diatheses, viz.: the urate, the oxalate and the phosphatic, one of which was the cause of renal stone in any given case. My own opinion is that with some rare exceptions the formation of primary kidney stone depends upon a predisposing cause which may be called the uric acid diathesis, and certain exciting causes incident to the food and surroundings of the individual, together with a precipitating cause without which stone is not deposited. The exciting causes determine the particular variety of calculus which may be found in any given case, but in the absence of the other two factors the exciting causes will not result in calculous deposit.

The mere presence of the diathesis alone will not cause the deposit of stone, for many persons habitually pass large quantities of uric acid without the development of any form of calculus. Ultzman has demonstrated that when the urine is only mildly acid, uric acid is deposited in normal rhombic prisms, but that if the acidity be increased the crystals take the form of elongated, pointed and radiating rods, and that it is precisely these spiny crystals that are found in cases of calculous pyelitis. Dr. Ord shows experimentally that the

form in which uric acid is deposited is often determined by the other urinary constituents. Eichorst cites a case where a gentleman invariably passed several uric acid concretions after drinking moderately of wine, and I have had under my care for some time a patient who is regularly attacked with renal colic during pregnancy, but at no other time.

Persons who are exposed to the same influences and who are similarly nourished, always have the same character of kidney infarction. Thus in the foetus and young infants, whose nourishment and surroundings are measurably the same, none but uric acid infarctions are found, but the conditions as to food and surroundings being changed other forms of deposit take place.

It would appear that dyspepsia has a considerable effect in determining the occurrence of calculous disease, hence those of sedentary habits are oftenest affected. A purely vegetable diet also seems to tend to the production of stone, and it is admitted by almost all authors that malt liquors have the same effect. Although not proven it is highly probable that diet has a considerable influence in the production of calculi. Cheshire, England, is almost exempt and the people live largely on a mixed diet, into which milk enters in no small amount, whilst Norfolk, with a population of between 400,000 and 500,000 has annually as many cases of calculous disease as the whole of Ireland, where milk also enters largely into the food of the people. Mr. Cadge believes that the great prevalence of stone in Norfolk is to be to a great extent accounted for by the inadequate supply of milk and to the universal prevalence of beer drinking. He is also of opinion that the effect of accumulated hereditary predisposition, in other words diathesis, is a factor entering largely into the causation of lithuria.

It is a doubtful question whether or not water containing lime salts favours the production of stone. My own limited experience would tend to support the opinion that water from limestone rocks has a tendency towards the production of renal stone. I have found that in the county of Welling-ton, along the Grand River, which runs through limestone rocks, calculous affections are comparatively common, so much so indeed that I rarely find myself without one or more patients suffering from calculous disease. I am at a loss to account for this prevalence of such disease on any other

* Read before the Ontario Medical Association, June 3rd, 1885.

hypothesis than that it is connected with the hardness of the water, for the food, clothing, habits of life, climate, etc., do not differ from the people around them. Dr. Roberts points out that a certain district, a suburb of Manchester, has furnished a considerably smaller number of cases of stone since the use of softer water supplied by water-works has taken the place of hard well water, and he gives no other explanation of the falling off in the number of cases.

Professor Gamgee draws attention to the fact that sheep pastured in limestone districts are particularly prone to become the victims of calculus, whilst under other conditions it is a rare affection amongst them.

In Finland, stone is an almost unknown disease, and the water coming mainly from granite mountains is remarkably pure. The Finlanders however are not addicted to excesses of any kind, live active lives and subsist on plain diet into which milk enters to a considerable extent. Estlander believes that the hot vapour baths common amongst them has a marked influence in securing that immunity which is so remarkable.

It would appear that the negro race are rarely affected with calculous disease, American statistics showing a proportion of not more than one to six of the white population. So far as my investigations have gone, I believe a similar immunity is enjoyed by the American Indian. It would appear that in these races the diathesis is less strongly marked, and that they are less exposed to those influences which tend to cause renal deposits, such as drinking strong or malt liquors, indigestion and sedentary habits.

There are renal stones which may be classed as purely accidental, such as those commonly occurring in Egypt, where the nucleus is found to consist of the ova of the *Diastoma hæmatobium*, also those instances in which blood clot, etc., forms the nucleus. In these cases the formation of stone is secondary, the nucleus being really a foreign body and consequently they ought to be classed separately from those arising idiopathically.

It is a rather remarkable rule, to which there are many exceptions, that only one kidney is affected by calculous deposit in the same patient. The explanation of this peculiarity which I would offer is, that inflammatory or catarrhal attacks probably affect only one kidney at one time as is usual in

other double organs such as the lungs, and that even a mild catarrhal attack produces a colloid material in persons predisposed to calculous disease. Rainey has shown by experiment that the presence of colloid matter causes the precipitation in spheroidal masses of crystalline salts, and this is the form in which uric acid nuclei are found. If only one kidney be attacked by the catarrhal inflammation or by congestion, that alone will be the seat of calculus; if both be attacked then stone formation may take place in both kidneys simultaneously. It might be objected to this theory that many victims of renal calculus have never had symptoms of catarrh of the kidney. My reply is that kidney catarrh usually presents no marked symptoms, and might very easily be overlooked, that in fact catarrh of the kidney is an exceedingly common occurrence. It may be caused by a glass or two of beer, by the chilling of the skin in a cold bath, even by purely mental causes as most people have had more or less demonstration of in their own persons. To epitomize, then, I believe that these three factors are necessary for the production of renal calculus. First a special diathesis, secondly certain exciting causes incident to the ingesta and surroundings of the person, and thirdly a catarrhal or inflammatory attack which acts as the direct cause of the deposit.

With reference to the treatment of an attack of renal colic, I may say that the advice commonly given, viz. : to administer belladonna, opium, diluents, etc., and to place the patient in a warm bath, with the application of wet cups or perhaps venesection, is utterly inadequate to relieve the frightful agony experienced during the passage of renal calculus along the ureter. I speak of what I know, having been myself a victim of the trouble in question, when I advise the administration of an anæsthetic in every case where the pain is severe. Authors generally say that occasionally an anæsthetic may be given. I would be rather inclined to say that one always must be given. Of course in addition, the treatment already mentioned may be employed with the exception of the blood letting which, to say the least, is entirely unnecessary.

As regards treatment to prevent the deposit of renal stone, what I have been in the habit of recommending is careful regulation of the diet and relief as far as possible of dyspeptic symptoms, the drinking of considerable quantities of water which

it is well to have as free from lime as possible ; frequent warm baths and the wearing of flannel next the skin ; plenty of out door exercise and the avoidance of beer and alcoholic liquors generally. As to medicine I have found nothing give so much relief as carbonate of lithia, in fact I have the greatest confidence in its value in cases of primary renal calculi or a tendency thereto.

Correspondence.

COLLEGE OF PHYSICIANS AND SURGEONS vs. QUACKERY.

To the Editor of the CANADA LANCET.

SIR :—Last fall a quack named Jones came to these enlightened regions, where he remained, doing a first class business, leading the people to believe he had the proper authority to practice, until about a month ago when he suddenly decamped, taking with him the daughter of one of our wealthy farmers, who patronised and opened his house to him. This Jones styled himself “ J. R. Jones in the profession of roots and herbs, of Milltown, Ont.” I was perplexed at the credulity of the people who told me of his doings, but not wishing to bring him before a magistrate, I wrote to Dr. Pyne, who promised to send a detective down, but the said official came too late to catch his victim.

Jones had his board and lodging gratis among the people for nearly nine months, and is said to have made nearly \$3000. He is about 6 ft. in height, wears a light moustache, and has the features of a hardened and desperate wretch. The detective was much disappointed to learn of his escape, but as there was enough material of the same kind to work up, he had “ Dr.” Gardiner of Bannockburn arrested, and fined \$28. This man has practiced openly for over ten years in this county ; has charged four times more for his medicine than any qualified person, and is let go free for \$28. During the last ten years the College has exacted \$10 from me, to protect me as I understand it, but if I had followed the advice of medical friends, I would not have paid a dollar, for many of them believe the College to be a farce.

The way that quackery is allowed to flourish here, is not at all encouraging to those who are thoroughly qualified, and besides, it is derogatory to the good name of our time-honored profession. The

physicians here have quite enough to do to live respectably, and in many instances they have to establish drug stores, for the practice of medicine would not keep them above want. Yet these quacks who infest our neighborhood, charge just what they please, and collect where we fail. Such practices are a direct encouragement to young men contemplating medicine, to take the road as quacks. The fact is, people seem to have more confidence in the quack, than in the possessor of the M.D., M.R.C.S., etc., etc., and the former makes more money, has less care, and is about as respectable in the eyes of nine-tenths of the people of Canada. With a view to protect ourselves and the public, every physician should, whenever a quack is known to be in his midst, notify the representative of the district of the fact, in order that a detective may be put on his track. It should also be the duty and privilege of the registrar, to erase the name of any member who lends his name and influence, to any travelling concern whose tendency is to deceive the public. Whenever the representatives and the College unite, to protect those who have fulfilled every requirement, all grievances will cease and the profession will be re-instated on its proper level.

PRO ARIS ET FOCIS.

M——, July 20, 1885.

Reports of Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

June 2nd, 1885.

The Vice-President in the chair.

Dr. McCargow exhibited the lower end of the femur of a man whose thigh had been amputated in the hospital by Dr. White. The patient, aged 36, had been admitted to the hospital with the following history :—At 14 years of age received a slight injury on the inner side of the thigh, while sleigh riding ; since then has had pain in the knee with swelling, chiefly during changes in the weather and in cold weather. Although knee has pained since the first with the exception of slight intermissions of a few weeks, he has never been confined to bed, and the only treatment has been in the form of external applications. Four months ago incisions were made and a large quantity of pus removed. When admitted, the lower half of

the right femur was found enlarged and hard. The swelling extended to the lower half of the right knee, and the patella was fixed; two openings had been made one on the outer, the other on the inner side of the thigh; the openings had partially closed, but there remained small sinuses from which pus discharged pretty freely. Patient was able to move about on crutches and was not confined to his bed in the ward. Family and personal history were both good, no record of anything specific. A longitudinal section of the bone was shown; there was an abscess cavity in the centre, with thickening and enlargement of the bone. The cavity was six inches long, one half inch wide, but irregular. The cartilage of the knee was intact. The diseased bone was twelve inches long altogether. Dr. Malloch said that when the section of the bone was made there was a piece of necrosed bone in the cavity which would account for the inflammation.

Dr. R. R. Wallace read a paper on "Incisions in Whitlow." Authorities were quoted to show the site of incision preferred. Erichsen recommended an incision on each side of the finger, while Fairlie Clarke advocated incision on one side; others preferred the median palmar; Keetley advised two palmar incisions. The essayist thought that incision in the median line over the ungual phalanx would be likely to divide the digital arteries as they there cross to form an arch, while the great argument in favour of the median incision had always been that it avoided such accident. He believed that in whitlow confined to the ungual phalanx, incision along the side, carried to the bone if necessary, is the best one to practice, for it affords exit to all pus and sloughs, and effectually relieves tension, thus removing the great cause of the agonizing pain, and avoiding at the same time a cicatrix on the most exposed portion of the finger where it impairs more or less the tactile sense. If the incision on one side was not sufficient, the double one should be practiced. When the disease had extended up the finger, and involved the sheath of the tendons, he thought there was no choice but to open the sheath and give exit to the pus, and this he considered was best done in the median line on the palmar aspect. With regard to the question of one long incision or separate ones between the joints, he thought that the arguments in favor of separate ones were

very strong, as there is less liability of causing strangulation over the shafts of the phalanges, and the tendons were not so much exposed or injured by the smaller incisions and the liability of sloughing lessened. Dr. Malloch expressed his surprise at the advocacy of the lateral incision. He said that Ashhurst recommended it because it avoided sloughing, but he himself had never seen it result from the median when incision was made early enough; the only difficulty was in keeping the incisions open, it being necessary to use the probe night and morning. The lateral incision, he thought, would go indirectly to the matter; there was no danger in wounding the arteries and nerves as they would heal readily enough. Other members who spoke all favored the median incision and a good free one.

The Vice-President, Dr. Stark, then showed a specimen, the first phalanx of the middle finger of the left hand. The history of the case was a blow followed by a swelling on the side of the finger, but not much pain; it was poulticed, but an incision was not allowed at first, and when opened it had to be done several times, and finally amputated, and was found to be much expanded, necrosis having evidently taken place.

July 7th, 1885.

The President, Dr. White, in the chair.

Specimens were shown by Dr. McCargow of two kidneys containing a number of gummatous growths, the following report being given of the case by Dr. J. Cochrane:—When the patient entered the hospital there was no history of syphilis to be obtained. Soon afterwards two growths like horns appeared on the forehead, evidently of a fibroid nature.—Afterwards chest symptoms appeared, there being effusion, which, after a small amount of fluid was withdrawn by a hypodermic needle, seemed to subside. There was also noticed a gradual hardening of all the glands of the body. Specific treatment was adopted but was of no benefit, the patient dying of exhaustion. Post mortem—there was thickening of the pleura and general adhesions; the cavity contained between eight and twelve ounces of fluid; there was also effusion into the pericardium. The left lung was healthy, but there was great fibroid thickening of the right, there being a fibrous band passing through it from pleura to pleura. Liver and spleen were healthy, but the kidneys were enlarged and congested and contained a num-

ber of large yellow gummata. The peritoneal glands were enlarged, while the glands of the groin were broken down. In reference to this case, Dr. Woolverton, under whose charge the patient had been, stated that at first she had indefinite pains in her legs; the growth on the right frontal region had increased in size up to the time of patient's death. Two months before, she began to have cough and continued elevation of temperature, the dulness extended rapidly and the chest was seen to be enlarged; after the exploratory aspiration the effusion seemed to decrease, and friction râles were heard, so further operation was postponed; the symptoms improved for a while, but afterwards enlargement again took place, and death at the last was rather quicker than expected. The disease of the lungs he considered to be syphilitic.

Dr. Malloch thought that it was a case of tertiary syphilis, and that the swellings on the scalp were not properly interpreted, for if their softness had been considered, they would not have been thought secondary, as they had been suspected to be.

The other specimens shown were a uterus with a growth attached to the fundus of the size of a strawberry, and two intermuscular growths, and a portion of cancerous liver. The history given by Dr. Cochrane was as follows: There were no definite symptoms at first except an inability to retain anything on the stomach, which was thought due to alcoholism; afterwards the condition of the liver was diagnosed. The patient's illness was not of long duration. Post mortem—the liver was found to weigh over five pounds and was studded with cancerous masses, some of them as large as half an orange. In regard to this case, Dr. Mullin inquired if there was any primary seat of the cancer, and was inclined to think it might be in the uterine growths. Dr. McCargow thought it was in the liver itself, and that all the symptoms pointed to malignancy. Dr. Mackelcan inquired if there was any ascites, as in his experience it was generally present in cancer of the liver. Dr. Griffin asked if there was any disease of the pancreas, but none had been observed.

Dr. Hillyer then read a paper on "Typhoid Fever," giving an account of an outbreak of an epidemic character which occurred in the county of Norfolk, in April, 1860. At the time there was a good deal of discussion as to the nature of the outbreak, some of the local physicians calling it typhus,

some pernicious, some typho-malarial, and others typhoid, there being such a variety of symptoms as to warrant the differences of opinion. The epidemic extended over an area of from 10 to 12 square miles, amongst a poverty-stricken and hardworking backwoods population. The disease was first noticed amongst lumbermen who had come from Illinois, where a similar epidemic had been raging. Out of five members in the first family attacked, the mother and three children died. The second family attacked were relations, and had visited the infected dwelling while they themselves lived in a one-roomed badly ventilated house. The symptoms presented by those attacked first were typical of the epidemic, and were as follows: epistaxis occurring early with decided chills, followed by fever, flushed and dusky complexion, accelerated pulse, furred tongue, and general feeling of languor and debility. After the first few days when there was an intermission, the fever gradually became continuous. Nervous symptoms also were present, viz: restlessness, aching of the back and limbs, headache and insomnia. The bowels were loose with the characteristic discharge. As the disease advanced, the pain increased in the right iliac region, abdomen became tympanitic, tongue dry, swollen and of a brownish color, which gradually increased to black. A petechial eruption appeared over the body, with sudamina on the neck and portions of the chest; black sordes appeared on the teeth and gums, and delirium with a general typhus condition supervened, while there was a pungent and penetrating odor from the body. The patients evinced great feebleness, while the skin showed great lack of vitality, sloughing taking place on blistered surfaces. Finally the pulse gave way and became excessively frequent and fluttering, the extremities cold and clammy, and the abdomen enormously distended. After referring to some cases which presented different symptoms, and more of a typhus character, there being no enteric symptoms, costiveness being present from the outset, while in others gastric symptoms were most prominent, he proceeded to speak of the contagiousness of the epidemic, instances being noted where those who had gone away to escape the disease had been stricken down with it, while on the other hand, those who had been constant in their attendance had in some cases escaped. Another feature of the epidemic spoken of, was, that for months, wherever its taint

extended, all forms of inflammatory action assumed an asthenic type, and typhoid symptoms were sure to develop. The writer then took up the nature of the epidemic, after which he gave an account of the treatment adopted. This was chiefly of an expectant nature with special treatment of an ordinary kind for the ordinary symptoms. A discussion followed, the general idea being that the epidemic was one of typhoid. Some conversation also took place on the question of what constituted typhoid fever, and whether it could exist without the special enteric symptoms.

NOVA SCOTIA MEDICAL SOCIETY.

This Society met at Halifax on Wednesday, June 17th, the President, Dr. Macpherson, of North Sydney, C.B., in the chair. Dr. Sinclair read an interesting paper on "New Remedies in Insanity and other Diseases of the Nervous System," and reviewed the evidence in favour of the four following remedies: 1. Paraldehyde. This drug was first introduced by Cernello, of Palermo, in 1882. It is formed from an aldehyde or dehydrogenated alcohol by the action of an acid, and has the formula $C_6H_{12}O_3$. When acted upon by chlorine it is said to be converted into chloral. It is a sedative and hypnotic, and its advocates claim that it has all the good qualities of chloral without its dangers. No nausea, depression or headache have been known to follow its free administration. The taste is disagreeable and difficult to disguise; the best vehicle is ice water in large quantity. The dose of paraldehyde is 3ss. to 3i. Dr. Andrews, who had experimented largely with the drug, thought it supplied no demand not already met by other agents, which had their own advantages. 2. Nitro-Glycerine, or Glonoine. The theory of its action is, that it reduces arterial tension by paralyzing the vaso-motor nerves, thereby dilating the blood vessels. It has been recommended in angina pectoris, valvular disease, weak dilated heart, albuminuria, chronic Bright's disease, asthma, epilepsy, migraine, and some forms of insanity. Dr. Sinclair's experience both with this drug and with nitrite of amyl, was that in epilepsy the number of fits were increased. 3. Jamaica dogwood (*Piscidia Erythrina*). He used it in doses of fifteen minims to 3ij. of the fluid extract. As an hypnotic it failed but proved satisfactory as an anodyne. In the severe frontal headache of epileptics, one drachm doses either alone or in combination with bromide

of potassium or chloral produced unquestionable benefit. In two cases of dysmenorrhœa, relief of most agonizing pain was speedily obtained. 4. Hyoscyamine and hyoscine. The writer began his experiments with the crystals, using a solution in glycerine and alcohol, and giving it in doses of $\frac{1}{6}$ to $\frac{1}{4}$ of a grain. In acute mania he produced the full physiological effects, and even when its toxic effects were present only temporary quiet was produced. Pushed to this extent grave symptoms were produced, such as irregular pulse and respiration, congestion of the head and face, cyanosis and dryness of the mouth and fauces. The freshly made fluid extract of hyoscyamus in doses of 3ss. to 3iss. gave much better results. He has practically discarded the crystals. The amorphous hyoscyamine is essentially distinct from the crystals and consists of at least two crystallizable salts, and to this compound it is proposed to apply the name hyoscine. It is a feeble sedative to the spinal and respiratory nerve centres and a dominant hypnotic upon the brain. In doses of $\frac{1}{100}$ gr. hypodermically it produces calm and sometimes sleep. Dr. Wood used it in nine cases of insanity with great violence and sleeplessness. In all cases quiet resulted and in some sleep, varying from 4 to 6 hours. He recommends it in asthma, whooping cough, and delirium tremens.

A discussion followed in which Drs. Parker, J. F. Black, Smith and Lindsay took part.

Dr. Farrell read a paper on "Excision of Joints," and gave the results of cases treated by him in the Halifax Hospital. Two patients were exhibited in whom the elbow had been excised with excellent results. The other cases referred to were, two of the knee and three of the hip. He laid great stress upon operating before suppuration began to discharge externally. For scrofulous arthritis, excision in almost all cases, is advisable. Under six and after forty the mortality is much greater than at intervening ages. Resection of the hip will be more frequently performed, the mortality being 25 per cent., when left alone 50 per cent.

An interesting discussion followed in which Drs. Muir, Macdonald, Stewart and Somers took part.

Dr. J. F. Black read a very interesting and lengthy paper on "American Medical Institutions," being notes taken in his recent visit to the hospitals of Montreal, New York and Philadelphia.

Dr. J. W. Macdonald read a paper on "Dynamite Accidents," with cases occurring in his practice as Medical Officer of the Steel Company of Canada. During the last five years he had found that an accident had occurred for every seven tons of the explosive used.

Dr. Dodge read an interesting paper on "Injuries of the Eye," with cases from his own practice. These cases were intended to illustrate various forms of injury to the cornea, iris and lens. Wounds of the cornea when made with a sharp cutting instrument were not necessarily serious, unless from their extent. When made with a rough irregular edge they were often very difficult cases to deal with. If the iris were wounded at the same time the injury was more formidable; and very soon severe inflammation led to more or less loss of sight, and if treatment were delayed for a few days total loss of vision frequently ensued. Wounds of the lens also often proved serious. Two very interesting cases were related in which a piece of metal was lodged in the iris; another a case of injury from gunpowder destroying the transparency of the greater part of the cornea, except the upper border, which was partly concealed by the lid. Iridectomy was afterwards performed and section of the superior rectus was subsequently made to uncover the clear portion of the cornea, allowing the ball to roll downwards and thus assist the sight. A case of wound of the cornea extending into the sclerotic was next given. A stitch was placed in the sclerotic and a good result followed.

Dr. Andrews read notes of a case of "Rupture of the Kidney," and Dr. DeWitt reported two cases of empyema successfully treated. Want of space prevents extended reference to these valuable papers.

Dr. A. P. Reed read a paper on "The progress of Medicine." Dr. Campbell on "Heredity as a Causative Influence in Progressive Muscular Atrophy." Dr. Moore on a peculiar case of "Mental Derangement due to Excessive Use of Alcohol." Dr. Stewart on "Physical Education," and Dr. Mackay (Reserve Mine), on "Cases of Obstetric Interest."

By a resolution of the Society Drs. Macdonald, Stewart and Mackay were requested to have their papers published.

The following officers were elected for the ensuing year: Dr. Stewart (Pictou), President; Drs. Sinclair and Mackay, Vice-Pres.; Dr. J. W. Macdonald, Secretary and Treasurer.

Selected Articles.

STRICTURE OF THE URETHRA.

The following cases of stricture of the urethra, under the care of Mr. Paul, Royal Southern Hospital, Liverpool, which we publish, are of interest, each of them being complicated and requiring special treatment. Wheelhouse's operation, which was performed in one case, was described by him in 1876; but, as Mr. Paul observes, it is not necessary to use the special instruments then brought forward, success being equally obtained with instruments which are in almost daily use.

CASE 1.—Josiah C—, aged fifty-four, a seaman, had suffered many years from stricture (he says thirty), but had never been treated for it. He sought admission on account of a perineal abscess. Under ether the abscess was opened, the stricture divided, and a full-sized gum-elastic catheter passed and tied in. On the third day the catheter came out and was not reintroduced, a Lister's bougie being passed daily instead. At the end of two months he was discharged almost well, but warned to attend as an out-patient for some time to get the bougie passed, as the stricture showed a strong tendency to contract again. He was an extremely nervous man, and once out of the hospital had not the pluck to continue treatment, the result being that in the course of a few months he had another urinary abscess worse than the first. He kept away from the hospital until he found that he was getting in a very bad way, when he returned in the following condition: the scrotum and the whole of the perineum and neighboring parts were brawny and tender. Just behind the former was a ragged, foul-smelling sore, eating deeply into the perineum along the tract of the original fistula. Its edges were hard and epitheliomatous in appearance, and upon scraping the surface of the sore the characteristic "nest cells" were found in abundance. The disease was too far advanced to permit of any attempt at removal, and came to a fatal end in about three months, the actual cause of death being cellulitis. At the post-mortem the growth was found to be limited to the perineum and neighboring glands, involving all the parts down to the arch of the pubis and spreading freely into the scrotum. The prostate and bladder were quite free.

Remarks.—I believe that this is a very rare sequence to a urinary fistula, and it is very unfortunate that there were no means by which the exact origin of the epithelioma could be determined. It is difficult to distinguish microscopically epithelioma of the bladder from epithelioma of the skin, and the same holds good with the urethra. The whole case lasted only ten months. When first seen, the skin of the perineum was unbroken, it was quite free from growth two months later,

and then, at the end of another five months, was the site of a large and very deep epithelioma. Under these circumstances, I inclined to the opinion that the growth commenced in the urethra, and was excited by the prolonged stricture; just as simple syphilitic stricture of the œsophagus sometimes ends in epithelioma of that structure.

CASE 2.—James P—, aged thirty-four, had gonorrhœa when a lad and had suffered from stricture for the last sixteen years. He had often been under treatment at the various hospitals in the town, but had never had anything larger than a No. 6 or 7 passed, except on one occasion when Mr. Harrison ruptured the stricture with Holt's dilator. After this he learnt to pass a catheter for himself, but had only used the smaller sizes, and came to the hospital, as he could get nothing more in and was scarcely able to pass his urine. On admission, he was in good general health. There was a cartilaginous stricture in the perineum which would just admit the smallest soft bougie. The urine was foul and contained a quantity of mucus. At the end of three days no dilatation had been effected with catheterism, and the bladder symptoms were becoming more urgent; Wheelhouse's operation was therefore performed at once. The patient was placed in the lithotomy position, and a long silver probe passed down to the stricture. An incision was then made on to the end of the probe, which was pushed out of the wound and bent into a hook. The sides of the urethra were held open with artery forceps, a grooved probe insinuated through the stricture, which was divided, and the probe passed on into the bladder. It was now quite easy to pass a full-sized Lister's bougie from the penis to the bladder; so the patient was sent back to bed without having a catheter tied in. At the end of a week the urine was quite clear and all irritation of the bladder had ceased; so, instead of the daily passage of a bougie, a large gum-elastic catheter was tied in. While the catheter was kept in all the urine came by it, and the wound healed rapidly. It was removed in ten days, and the patient taught to pass a No. 12 Lister's bougie, and discharged a few days later. Altogether he was in the hospital only from Jan. 12th to Feb. 7th.

Remarks.—I send this straightforward case for publication because I have so often felt the advantage of an early operation of this nature in stricture cases, and because I often notice that my surgical friends, while they laud the method advocated by Mr. Wheelhouse very rarely seem to adopt it. In the hands of specialists internal operations upon the urethra are much in vogue; at present I have never either split or divided internally a stricture, except in the penis, preferring in all cases where an operation is necessary to do perineal section. I think it is a pity that Mr. Wheelhouse recommends special instruments for

his operation, as it is quite as easy to do it with those always at hand; and, with all due deference to his opinion, I do not find his sound and forget of any material assistance, while their absence might influence some to attempt a different method of giving the necessary relief to the patient. In this case a catheter was not tied in at once on account of the cystitis; and at the conclusion of the treatment I adopted my usual practice of teaching the patient to pass a large metal sound for himself. It is the only permanent cure for most strictures, though but few, of the hospital class at any rate, are wise enough to adopt it.

CASE 3.—James F—, aged twenty-seven, had gonorrhœa some years ago, but passed urine in a full stream until about twelve months back, when he had his first attack of retention of urine after a drinking bout. Since then, under similar circumstances, he has had three or four more attacks of retention, and at the same time the stream of urine has been steadily diminishing in volume during the intervals. On Feb. 2nd he was drinking, and on the morning of the 3rd was again attacked with sudden and complete retention. Relief had been attempted by catheter, and he bled profusely, but no urine was drawn off. He was admitted with the bladder moderately distended in the afternoon, and was in great pain. A metal catheter was passed into the urethra, but opposite the bulb left it for a false passage, and on withdrawing the instrument he at once strained away about an ounce of blood. Under these circumstances a morphia injection was given, and he was ordered to have a hot bath shortly, to be followed by hot fomentations to the abdomen, and further morphia if necessary. In the evening, though the treatment had given some relief, not a drop of urine had been passed, and it was therefore deemed advisable to puncture per rectum. The next day he was perfectly comfortable, and the urine was draining freely through the canula. On the 5th, after plugging the tube, he was able to pass urine by the penis, and it was consequently withdrawn. 6th.—Had a rigor, with nausea, headache, and diarrhœa. Temperature 104°. Ordered five grains of quinine every four hours. 7th.—Temperature fell below 100°, and became normal in a few days. The quinine was stopped on the 9th. 12th.—Soft bougies passed. No. 3 was the first to be gripped by the stricture, which was dilated to No. 6. 24th.—The patient was discharged with the stricture fully dilated.

Remarks.—In a case of this kind, I think the choice lay simply between aspiration of the bladder and puncture per rectum. I chose the latter entirely on account of the false passage. In acute retention, when, though the urethra is uninjured, no instrument can be passed, aspiration is called for, and will almost invariably not have to be repeated, since the relief afforded by it, together

with other suitable treatment, will permit the swelling and spasm of the urethra to subside, and in the course of twelve hours either the patient will have passed urine naturally, or it will be possible to introduce a catheter. But when a false passage is present, and it is extremely inadvisable to interfere with the urethra for a least a week or ten days, the better plan is certainly to adopt puncture per rectum, and retain the canula *in situ* until the power to micturate has returned. The pyrexial attack on the 6th I believe to have been due to some urine filtering into the false passage and permitting septic absorption, as no instrument was passed until the 12th, and no trouble of any kind appeared in connection with the rectal puncture. I am a strong advocate for early operation in all cases of obstruction to the outflow of urine, when that obstruction cannot be easily overcome by catheterism. We ought to remember that the kidneys are the only part of the urinary tract of vital importance, and, sooner than permit their structure to be damaged, a clean incision should always be made into the urethra or bladder, as the case may require. Sadly too often, while we are wasting time over a cartilaginous stricture with small bougies, pyelitis is grafted on to cystitis, and suppurative nephritis may develop at any moment, and show too late the danger of delay.—*Lancet*.

A CASE OF TRAUMATIC ANEURISM.—In the *New York Medical Journal* for May 23rd Dr. Theodore McGraw of Detroit relates an interesting case of traumatic aneurism of the subscapular artery. The patient was a Pole twenty-seven years of age, who received three stabs about the shoulder in December, 1881, one of which was followed by an enormous extravasation of blood that was in due course absorbed. Three years later he came under Dr. McGraw's care with a rapidly growing pulsating swelling in the axilla, which had all the usual characters of an aneurism. There was no alteration of the radial pulse. Its increase in size was so rapid that treatment had to be resorted to at once. The first step of the operation was to make an incision above the clavicle, through which the subclavian artery could be compressed. A free incision was then made over the tumour, and carried through the pectoralis major muscle, and attempts were made to detach the thick sac of the aneurism from the surrounding structures. When this step of the operation was about half completed, the sac ruptured, and thinking that the attempt to isolate it must be abandoned, the sac was freely laid open, and the mouth of the artery controlled by the finger; but after many efforts it was found quite impracticable to free the mouth of the artery and to throw a ligature around it, for the sac was formed of very dense tissue, and was firmly adherent around the wounded artery. Dr. McGraw thereupon returned to his original plan, and

with ease separated the fundus of the sac from the ribs and the anterior and posterior walls of the axilla, and then ligatured its neck. After this the axillary artery was with comparative ease freed and tied above and below the origin of the subscapular branch, which was found to open into the aneurism within half an inch from the parent trunk. Arguing from this case, Dr. McGraw advises that while Syme's operation is suitable for cases of ruptured artery, it should not be adopted for traumatic aneurism where there is a well-formed sac. It is pointed out that it may be impossible from the interior of an aneurism to free the artery sufficiently to ligature it without imperilling contiguous arteries, veins, or nerves, while the detachment of the sac may be a comparatively easy and rapid procedure if done systematically. A ligature can then be tied around the neck of the tumour, and all danger of hemorrhage avoided, and if the fundus of the sac be cut away the field is comparatively clear for the final steps of the operation. It is undoubtedly a dangerous and difficult matter to clear an artery from the inside of the sac of an aneurism, and where the sac is sufficiently dense to permit of it, the plan of operating proposed by Dr. McGraw offers decided advantages.—*Lancet*.

THE USE AND ABUSE OF THE TAMPON IN ABORTION.—The tampon as a means of arresting hæmorrhage from the cavities of the body or from wounds has been known to the profession for many years. It seems a very natural thing, when blood is escaping with dangerous rapidity, to apply a plug of some sort to stop the leak. There are some things to be guarded against, however. That the bleeding is actually arrested, and not merely diverted into another channel, is of primary importance. Again, there are conditions in which the plug may do mischief. As applied to uterine hæmorrhages, these two elementary principles are so well known that no one will question the correctness of either. A woman with the vagina firmly plugged may bleed to death into the cavity of the uterus. A tampon allowed to remain too long may do harm in various ways. A tampon injudiciously applied may precipitate the catastrophe it was intended to avert. Of this injudicious application of the tampon in cases of threatened abortion it is the purpose of this paper to treat.

Dr. Keene then quotes the views of Leishman, Playfair, Tyler Smith, Cazeaux, Shroeder, Lusk and others and says: Now, out of this mass of authority, sometimes conflicting, but generally unanimous, what deductions are to be drawn? That the tampon is to be used as a last resort, and only where the hæmorrhage is dangerous or the abortion clearly inevitable. We have, moreover, the observation of so experienced an obstetrician as Shroeder, that the hæmorrhage of abortion is seldom dangerous and scarcely ever fatal—a view which

Lusk seems to share. Of course, in their hospital experience, a physician is always at hand to meet any emergency, while in private practice, and especially in the country, another condition of things prevails. Yet it seems that enough has been said to indicate plainly that the routine practice of plugging, in threatened abortion with but slight hæmorrhage, merely as a precautionary proceeding, has no countenance from the authorities.

Besides the natural bias of the physician's mental makeup—his individual personal equation—his views will vary as his experience has been large or small. To a beginner, the loss of a slight amount of blood from the uterus of a pregnant woman is fraught with direful forebodings. As his experience widens, hæmorrhage will become dangerous less frequently, abortion will take its place under the inevitable class with much less facility, and the tampon will be employed only to fulfil its two legitimate indications.

The young practitioner is not the only offender in the over-free use of the tampon. His older brother may well look to the well-worn grooves in which his practice moves more or less smoothly to discover whether he, too is not a devotee of the tenet that the fœtus has no rights which the physician is bound to respect. The tampon is legitimately employed only when for good and sufficient reasons it is necessary to terminate gestation.—*Dr. J. W. Keene, New York Med. Journal.*

CONFESSION NO PROOF OF GUILT.—The *Lyon Medical*, of April 28th, 1882, refers to the case of a girl, aged twenty, supposed to be seven months pregnant. After an attack of hemorrhage, her size seemed to have considerably diminished; and the girl being closely questioned on the subject, said that, becoming aware of the discharge, she repaired to the closet, where she stayed ten minutes. She added that all had escaped, but that she had not time to look, as she was being called by her mistress. A midwife and the parish surgeon both declared that the girl had been recently confined. She was now again assailed with questions, and told that, for her own sake, she had better make a clean breast of it, as no fœtus had been found in the closet. Perhaps, it was suggested, she had thrown it into the pigsty. The poor creature at first denied such a thing, but at last confessed that it was so. A search was made but no child was discovered. She was tried for concealment of birth, on her own confession, and sentenced to six months imprisonment. The girl had not been taken into custody in consideration of her free confession, and she quietly proceeded to the goal. When admitted, it was found that she was far advanced in pregnancy, and soon gave birth to a healthy girl. By the French law she could no longer appeal, as more than ten days had elapsed since the verdict; but the judge, having the power of appealing within two months, did so, and the girl was acquitted.

This case shows that confession, which is looked upon as the clearest proof of guilt, can not always be relied upon. And what shall we say of the surgeon and midwife? The examination was probably hurried and incomplete, and the conclusion arrived at on seeing the signs of recent abundant hemorrhage. This case, even in a simple obstetrical point of view, is full of valuable hints.

TREATMENT OF HEMORRHAGE AFTER OPERATIONS ON THE RECTUM.—Mr. Samuel Benton (*British Medical Journal*) brings to the notice of the profession a useful instrument for checking hemorrhage after rectal operations. It consists essentially of a piece of catheter tubing surrounded by a bag of thin rubber. When introduced into the rectum, the rubber bag is inflated to any extent required, and so a considerable amount of pressure may be brought to bear on the bleeding surface, in the same way that a similar apparatus is used for the relief of epistaxis. Mr. Benton's bag is constricted in the middle (like a Barnes' bag), so the amount of pressure on the sphincter will not be too severe. The catheter tube, by allowing the escape of flatus, contributes much to the comfort of the patient. The inventor considers that, in addition to its use as a hæmostatic, it will prove serviceable in the treatment of some rectal diseases where even pressure is indicated, as in non-malignant tumors of the rectum.—*Annals of Surgery.*

ENDOCARDITIS.—When endocarditis is found to be present, Dr. C. Paul, *L'Union Méd.*, applies a large blister over the region of the heart, orders rest, and prescribes some cool acidulated drink. If the disease occurs with articular rheumatism and sali-cylate of soda or sulphate of quinine is found efficacious, its use is continued as long as the pulse is not too rapid and irregular. If, however, the heart's action is disturbed, tincture of digitalis is to be given in doses of twenty drops twice a day, and gradually increased to sixty or eighty drops. The dose should not be increased until two days have elapsed, and as soon as the heart's action becomes regular the remedy may be diminished in quantity or suspended. The tincture of convallaria maialis, in doses of seventy-five minims per diem, may be given in place of the digitalis. As soon as the pulse becomes regular, recourse must be had to tonics, and especially the soluble ferruginous preparations.—*N. Y. Med. Record*, May 23d.

BRONCHITIS WITH VALVULAR HEART DISEASE.—Prof. Bruen, Phila., at his clinic, speaking of such a case, said:

My own experience in the treatment of simple bronchitis has been that the expectorants designed to increase secretion of the bronchial mucous membrane may be at first freely given; but their

use should not be prolonged, but should soon be substituted by the stimulative expectorants. I have found that if the bronchitis is not rapidly cured by these, but passes into a subacute condition, more can be accomplished by building up the general strength than by acting on the bronchial mucous membrane directly. In cases of cardiac bronchitis a great deal can be accomplished by building, not only by acting on the heart directly, but also by the use of such drugs as strychnia, arsenic, and iron.

We shall prescribe for this man the following pill :

R	Strychniæ sulphatis,	
	Acid. arseniosi	aa gr. ss.
	Pil. ferri carb.	grs. xxiv.
	Oleo-resinæ capsici	gtt. vj.
	Extracti gentian	grs. xij.

M. et. ft. pil. No. 24.

Sig.—One, three times a day.

An especial reason for using strychnia is that it increases the depth of the respirations, and thereby facilitates oxygenation of the blood, which is interfered with by the weak heart.—*Med. & Surg. Rep.*, May 23rd.

HAY FEVER AND ITS TREATMENT.—In this connection we may call attention to the new work of Dr. Sajous on "Hay Fever and its Successful Treatment." According to his views, hay fever would exemplify that form of asthma which Curschmann has never met,—the form in which the cause resides in the brain and nervous paths which lead from the brain to the respiratory apparatus. For, according to Dr. Sajous, persons subject to hay asthma possess, as the result of heredity, diseases implicating markedly the nervous system, nerve centres which have become abnormally sensitive and are therefore inordinately influenced by the external irritants to which they respond. But this is not the whole of the pathology of hay asthma, according to Dr. Sajous. Not only must there be a hyper-excitability of the nerve centres, but the nasal mucous membrane must be hyperæsthetic, and capable of transmitting to the abnormally sensitive nerve centres the impression made upon them by external irritants, which are supposed to be the pollen of flowers and certain other unknown elements which prevail only from June to September. Given the absence of any one of these conditions and the patient is spared the attack. The absence of the physical element, whatever it may be, which causes the irritation may be secured by removal to certain localities where it does not prevail.

Dr. Sajous secures the removal of the irritable mucous membrane by eliminating, first, the abnormal conditions of the mucous membrane, that is the swellings, hyperostoses, etc., by suitable treatment; and second, by cauterizing the hyperæsthetic nasal mucous membrane, and thus rendering it in-

susceptible to the irritating agencies. This is the new and successful treatment of hay asthma, in the early use of which Drs. W. H. Daly, of Pittsburg, J. A. Roe, of Rochester, and Prof. Harrison Allen, of Philadelphia, have, also, been conspicuous. We sincerely hope that further experience may confirm these preliminary statements, and that "hay" or "rose" asthma may no longer be the opprobrium it has always been to the science of medicine.—*Med. News*.

COCAINE IN BURNS.—Dr. Weiss writes :—On December 25th, I was called to Professor L—. An atomiser he was using had exploded, and the hot steam badly scalded the Professor's lips, nose, cheeks, and forehead. Pain was so intense that I apprehended general convulsions. I sent for sundry topical remedies, amongst them a two per cent-solution of hydrochlorate of cocaine. In the meanwhile I covered the injured parts with pieces of cloth dipped in olive oil; on the top of these I applied ice water compresses, renewing them every minute, without affording the slightest relief. When the medicaments arrived, I touched the injured parts with a hair-pencil dipped in the cocaine solution. I had scarcely finished when all pain had entirely vanished, without any return. At my visit in the evening I found the patient quite easy and in good spirits.—*Wiener med. Woch.* Jan. 8, 1885.
[It is also useful in the treatment of sore nipples.]

AN INGENIOUS EXPEDIENT.—Recently I was called to examine a woman who has had vesicovaginal fistula for years. The sufferer has kept herself cleanly and comfortable by using in the vagina a globular pessary made of compact sponge. The fistulous opening is near the urethral outlet; and the pessary holds the false orifice so high that the urine can be retained for hours. The patient never urinates, but evacuates the bladder every three or four hours through the agency of a catheter—an instrument she has become expert in using. The expedient might possibly be adopted in some cases where an operation for closure of the rent is not practicable. I commend the ingenuity of the woman who, unaided by even a professional suggestion, has kept herself from being offensive to herself and others.—*Eclectic Medical Journal*.

ENTERITIS CAUSED BY CORROSIVE SUBLIMATE.—Dr. J. L. Peabody read a paper recently before the Practitioner's Society of New York, on toxic enteritis caused by corrosive sublimate as a surgical dressing. Attention was first directed to this by reports of cases found in German medical journals. In the records of the New York Hospital eleven cases were recorded in which an obstinate diarrhœa followed the use of sublimate as a surgical dressing. Seven of these proved fatal. Autopsies in three of them showed extensive diphtheritic inflammation of the large intestine.

THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science
Criticism and News.**

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.

INTERNATIONAL MEDICAL CONGRESS.

Our readers are already aware that it is intended to hold the International Medical Congress in Washington in 1877. A committee of arrangements consisting of seven members, with power to add to its numbers, was appointed at the meeting of the American Medical Association in 1884, to extend an invitation to the Congress to meet at Washington, and in case of an acceptance, to make all necessary arrangements for the meeting and to solicit funds for that purpose. This committee was composed of Drs. Austin Flint, Sr., and L. A. Sayre, New York; I. Minis Hays, Philadelphia; C. Johnson, Baltimore; H. F. Campbell, Georgia, and J. S. Billings and J. M. Browne, of the U. S. army and navy respectively. The invitation was accepted, and to this committee about twenty additional members were added, among others, some "new code" men of note, and a meeting was held in Washington and a plan of organization adopted. The list of officers, and numbers of sections (nineteen in all) were published in the medical journals of the United States and foreign countries, and met with general approval. Everything went smoothly as a marriage bell until the meeting of the American Medical Association in New Orleans in May last, when a few turbulent spirits of the "rule or ruin" type, to be found in all assemblies, took exception to the action of the committee on the ground, first,

that it had recognized "new code" men; and, secondly, that the south and west were not fairly represented in the Congress, the majority of the officers having been chosen from among the eminent names in the East—New York, Boston and Philadelphia. "New code" prejudices and local jealousies were too much for the serenity of the Association, and the upshot was the appointment of a mammoth committee of 38 members, representing every State and Territory in the Union, Army, Navy, etc., to be added to the original committee, with power to alter or amend the action of the former committee, as it might deem best. This committee met in Chicago on the 24th of June, and, as might have been expected, there was a lively time. Only two members of the original committee put in an appearance, viz., Drs. J. S. Billings and I. Minis Hays, while twenty-four of the new members were present. Dr. Cole, of California, was appointed chairman, and Dr. Shoemaker (one of the leaders in the crusade against the original committee) was appointed secretary. The committee then proceeded to the work of revision. They first deposed Dr. Bowditch, of Boston, from the vice-presidency of the Congress, because of alleged "new code" sympathies. The following chairmen of sections ("new coders") were also deposed, viz., Dr. Noyes, on Ophthalmology, Dr. Lefferts, on Laryngology, and Dr. Jacobi, on Diseases of Children. The nineteen sections were reduced to sixteen, and the membership of the Congress was confined to delegates from the American Medical Association and societies in affiliation with it, thus excluding all from the Congress who are not in full sympathy with the American Association, and carrying the "code" quarrel into the Congress. When the result of the committee's deliberations became known, meetings of those interested were held in Boston, New York, Philadelphia, Baltimore and Washington, and resolutions were passed expressive of disapproval of the action of the committee, and refusing to have anything to do with the Congress under the present regime.

This action on the part of the leading members of the profession seems a most serious step, but it arises from the fact that there is a growing want of confidence in the ability of the American Medical Association, as an organization, to carry out such an undertaking satisfactorily, and also in the pro-

bable success of any Congress from which the best known scientific men of the country are excluded. The action of the committee in regard to the "new code" men would indeed be ludicrous were it not so serious, and will have the effect of creating sympathy, where before there was only cold and formal respect. The insult offered to such veterans as Bowditch, Fordyce Barker, Draper, Weir, Mundé, Roosa, Knapp, Noyes, Agnew, Jacobi, and others, merely because of a difference of opinion on the code question, will not be tolerated by the good sense of the American medical profession.

We presume matters will probably remain in *statu quo* until the next meeting of the Association in St. Louis, when the whole question will be gone over again. We have faith in the good judgment of the medical profession, and believe that a way will be found out of the confusion and complication into which this matter has drifted.

SUICIDE AND THE MEDICAL PROFESSION IN ILLINOIS.

The oft-repeated remark, that doctors carry on their shoulders more than a full share of the troubles of this life, finds a curious confirmation in the last necrological report of the Illinois State Board of Health. In this report are to be found a few unpretending figures, which, upon a more careful examination than that bestowed by the compiler, are found to be full of meaning and melancholy interest. It is to be hoped that in its next report the Illinois State Board of Health will supplement its figures by as full information as possible regarding some important points touching that part of their report to which we call attention. In this report it is stated that 202 physicians died during the previous year in Illinois. Of this number, six are reported as having died from suicide, five from "overdose of morphia," and two from "overdose of chloral." The reported suicides form about three per cent. of the deaths, a percentage in itself out of all proportion to what obtains amongst other classes of the population. But in addition, seven deaths are reported as having occurred from overdose of morphia and chloral—or over three per cent. of the total deaths. We all know that suicides take place which are never reported. Relatives and friends have numerous motives for suppressing

the facts. This is comparatively easy in the case of invalids or chronic drinkers, especially when sedatives are the weapons of self-destruction resorted to. If this be true as regards the general public, it is much more so as regards medical men, who have every facility for quietly ending their own lives in this way. In the report before us it is not stated that a single physician died from the careless or accidental use of any other poisonous agent. This looks suspicious. Of course medical men, like other mortals, have aches and pains to soothe, and suffer from insomnia, but that is no reason why they should kill themselves in greater numbers than they do their patients. The unvarnished truth is, that the "overdose," as regards the seven cases above mentioned, was simply the invention of friends interested in suppressing the real facts. If we allow two deaths by overdose, which is quite enough, that will make eleven deaths by suicide, instead of six as reported. We cannot be far astray in our estimate of the "overdose" cases in this instance, but when we come to estimate the number of unreported suicides we have entered the field of conjecture, and each one will have his own opinion. No one will deny but such occurred, while many will be apt to conclude that the number is relatively considerable. In the instance before us we shall suppose that three such cases occurred. That will give us fourteen suicides out of 202 deaths, or about seven per cent. Where so many suicides take place there must be a great many in the profession living in a state of utter misery and despair.

In this country we feel thankful to be able to say that no approach to such a condition exists. It is rarely, indeed, that a medical man in Canada dies by the act of his own hand. It would be interesting to know something of the professional standing and habits of these Illinois suicides, for that would afford some clue as to the cause or causes of a condition of things which we hope is exceptional, even as regards the other States of the Union. In this country insanity and drink are regarded as almost the sole causes of suicide in the case of medical men, especially the latter cause. But the native American is temperate, and we are assured that the great majority of American doctors are total abstainers. Drunkenness, therefore, cannot be said to be the most important factor. The most fruitful cause, most probably, is the over-

crowding consequent upon a low standard of general and professional education, or the absence of any standard worthy of the name. In the United States there is one doctor (so called) to every 600 of the population, and Illinois has its full quota, although it has rid itself, through the aid of recent legislation, of a large number of its quacks. The better element, under the new law, is forcing quackery into the background, and as a consequence we may safely assume, the most incompetent find themselves in desperate straits as the people become informed, and as medical men in increasing numbers become better educated, both in a literary and professional sense, so as to take a higher stand—not only professionally, but socially as well—the harder will be the lot of the poorly qualified and the mere charlatan. Perhaps, after all, it is better for society that these should continue the process of self-destruction than go on taking the lives of others.

The profession in Ontario, no less than the people at large, have much to be thankful for. Here no one can publicly practice who has not been found qualified after strict examination. This examination is not made by distinct schools, colleges or authorities, but by appointment of a central and independent authority called the Medical Council. This Council not being the creation, and hence not the creature of any existing authority save the law that constituted it, but a true representation of the profession by fair and open election, and as it is clothed with unlimited power, both as to the preliminary and final fitness of candidates, no one need fear that the standard will ever be too low or that the ranks will ever become much more crowded than they are. When undue overcrowding does take place, the remedy lies in raising the standard, and this power lies in the Council. No country can show brighter, better educated, or more able men in all respects, than the United States of America, yet, owing to imperfect laws, or the absence of all law, no country is so overrun with uneducated and half-educated doctors. Year by year the lot of the mere pretender will become harder and harder. All over the Union restrictive laws are fast replacing "free trade," and everywhere education and professional skill are becoming more and more in demand.

In view of these and other facts which might be mentioned, it is the duty of every one of us to

stand firmly by our privileges, to hold them fast, and to support our representatives in the performance of their duties by a cheerful compliance with the reasonable demands made upon us. The medical men of any State in the Union, would only be too glad to tax themselves ten times the amount asked of us for like privileges and immunities.

CANADA MEDICAL ASSOCIATION.—We would specially direct our reader's attention to the notice of meeting of the Canada Medical Association in our advertising pages. It will be seen that on application to the general secretary, Dr. Stewart of Montreal, all regular members of the profession will be furnished with certificates entitling them to purchase tickets at reduced railway rates. We are pleased to learn that the number of papers already promised is a sufficient guarantee that the Chatham meeting will fully equal its predecessors not only in the number, but also in the high value of its communications. The following are the officers of the Association—President, Dr. Osler of Philadelphia; General Secretary, Dr. James Stewart, Montreal; Treasurer, Dr. Charles Sheard, Toronto; Vice-Presidents, Drs. Bray of Chatham, George Ross of Montreal, Allison of St. John, Fraser of Windsor and Whiteford of Winnipeg. Local Secretaries, Drs. Burt of Paris, Bell of Montreal, Walker of St. John, Almon of Halifax, and Mewburn of Winnipeg.

COCAINE IN HAY-FEVER.—Now that the season for hay-fever is upon us it may not be out of place to state that great benefit has been obtained by a number of observers from the use of cocaine. Among others Dr. Watson of the Westminster Hospital, London, Eng., gives an account in the *Lancet* for July 4th, of the benefit obtained by him from the use of tablets of cocaine. The tablet which contains $\frac{1}{6}$ of a grain of muriate of cocaine is moistened in the mouth and one introduced into each nostril. They adhere without difficulty and give immediate and complete relief. Menthol in alcohol solution has been used by some as a substitute for cocaine, but is not so lasting in its effect.

CHOLERA INOCULATION.—The French commission has returned home disgusted with Dr. Ferràn's inoculation experiments. He positively refused to allow the commission to carry off a single bit of vaccine matter, or to make known his method of

preparing it. His laboratory is poorly equipped, possessing none of the modern appliances, not even an apparatus for regulating the temperature of the stove in which the cholera virus is cultivated for attenuation. He told the commissioners that he could not surrender his secret without a "guarantee." Dr. Ferràn's whole course of action creates the suspicion that he is either a deluded scientist or a humbug, or both.

PERSONAL.—Dr. W. F. Coleman, formerly of St. John, N. B., has finally settled in Chicago. The following resolution was unanimously adopted by the St. John Medical Society, on his removal from St. John.

Resolved, That this society give expression to their high appreciation of Dr. Coleman's scientific attainments, gentlemanly bearing, and untiring professional zeal. While deeply regretting the loss that the society and the profession will sustain by his removal, we confidently predict for him a very large measure of success in his new sphere, believing, as we do, that he possesses all the elements of a first class practitioner.

JAS. H. GRAY, M.D., *President*.

T. M. MUSGROVE, M.D., *Secretary*.

NEW METHOD OF COMPRESSING THE SUBCLAVIAN ARTERY.—Dr. Joseph Bell exhibited before the Med-chirurg-Society, Edin., (*Lancet*, June 13, '85), a case of amputation of the arm for extensive sarcomatous disease of the scapula. The hemorrhage had been controlled by a method recommended to him by Prof. Chiene, in which a curved steel skewer was passed from above downwards behind the subclavian trunks, and brought out in front through the pectoral muscles. Pressure was exerted on the vessels by an elastic tube applied as a figure-of-8 over the anterior part of the region transfixed, a firm pad intervening between the elastic tubing and the patient's skin. The method is similar to that used by the late Prof. Spence in the case of the femoral artery in amputation at the hip-joint. In this case Dr. Bell found the method perfectly satisfactory, as the limb was removed with the loss of but two ounces of blood.

CARBUNCLE.—Dr. Bulkley read a paper before the American Medical Association on this subject. He is strongly in favor of allowing a carbuncle to break naturally. He contends that when a carbun-

cle is incised there is more danger of pus being absorbed. He also opposes poultices. He gives sulphite of calcium, in quarter-grain doses, every two hours; sulphate of magnesia, in laxative doses, three times per day, and tonic doses of sulphate of iron. He also makes an application to the carbuncle of solid extract of ergot, two drachms; oxide of zinc, one drachm; and two ounces of rose-water ointment. The preparation is spread upon lint and applied directly. He thinks this reduces pain and cuts short the disease.

DIAGNOSIS OF GONORRHOEA IN THE FEMALE.—The differential diagnosis between gonorrhœa and simple vaginitis, is usually not an easy task. It has recently been asserted, however, by M. Martineau, of Paris, that the pus of gonorrhœa is acid in reaction, while that of simple vaginitis is alkaline. If this be true, a piece of litmus paper will invariably determine the true nature of the case. The test is easily applied, and if reliable its importance is very great.

AMALGAMATION OF MEDICAL COLLEGES.—The Detroit Medical College and Michigan College of Medicine have been recently consolidated, and will begin their first session's work on the 23rd of September next. See announcement in another column.

CORRECTION.—In the article on Intra-Uterine Medication, by Dr. Temple, in our last issue, an error crept in on page 321, eighth line from top, in first column. It should read *one drachm* instead of one ounce.

APPOINTMENTS.—Dr. Wm. McClure has been appointed Medical Superintendent of the Montreal General Hospital.

The *Canadian Practitioner* expresses the hope that the question of "consultations with Homœopaths" will be discussed by the Canada Medical Association at the meeting in Chatham. We can assure our sanguine contemporary that the Association will do nothing of the kind. Moreover, we do not believe that it can be satisfactorily proven that members of the Association are "in the habit of consulting with homœopaths and other irregular practitioners."

We regret to announce the sudden and unex-

pected death of the wife of Dr. C. W. Covernton, of this city, in the sixty-sixth year of her age. She will be greatly missed by her large family and a numerous circle of friends. The doctor and family have our deepest sympathy in their sad bereavement.

COMPOUND FRACTURES.—Dr. W. P. Verity, of Chicago, read a paper before the American Medical Association on the "Treatment of Compound Fractures by Wiring and Drainage." In all cases of compound comminuted fractures coming under his care, he first cleansed the parts and removed all loose fragments likely to produce irritation. He is, however, opposed to removing any fragments that can be wired, as they are needed for support. All the sharp edges should be removed and the bones firmly wired together, and free drainage provided for by large drainage-tubes. The limb should then be covered with antiseptic dressing and incased in a plaster cast, which should be removed at each dressing. The advantages claimed for his treatment are that there is no shortening, union is more rapid, and no extension is required.

CHRONIC CERVICAL ENDOMETRITIS—Dr. T. Gaillard Thomas speaks highly of the following in this affection :

R	Magnes sulphatis,	3 ii ;
	Ferri sulphatis,	gr. xvi ;
	Acid. Sulph. dil.,	3 i ;
	Aquæ,	O i ;

M.

Sig. Two tablespoonfuls in a tumbler of ice-water daily on risidg.

Dr. RYERSON, of Toronto, acting surgeon of the Royal Grenadiers, who has been away with the North-West expedition, has returned and resumed practice. The Dr. was through the Fish Creek and Batoche engagements, and the subsequent operations of Gen. Middleton's column.

We beg leave to call attention to the elegant inset of Hazen Morse in this and last issue of the LANCET. His preparations have been before the profession for several years, and are constantly growing in professional favor.

Mr. John Eric Erichsen, author of the work on Surgery which bears his name, and Mr. Ernest Hart, editor of the *Brit. Med. Journal*, will be

candidates for Parliamentary honors at the next election.

The McIntosh Galvanic and Faradic Co. have been awarded the Gold Medal at the New Orleans Exhibition.

Books and Pamphlets.

CHOLERA : Its origin, history, causation, symptoms, lesions, prevention, and treatment. By Alfred Stillé, M.D., LL.D., etc., etc. Philadelphia : Lea Brothers & Co.

Professor Stillé has contrived to compress into a little octavo of 162 pages all that he has felt called upon to say in relation to the absorbing subject of Asiatic cholera. He is a very decided contagionist. This doctrine seems to be as much favored now, as fifty years ago it was centemned. The logic of stern facts has been too powerful for the fancies of optimistic doctrinaires, and medical men of the present day have awakened to the old fact that two and two make four, and that no quantity of nonsense, added to an unknown quantity of baseless assumption, will be the equivalent of ever so fractional a part of truth. Dr. Stillé may be said to have been on the best terms of authoristic concordance with the writers of the May volume of W. Wood & Co. ; in fact they so reciprocally borrow and lend that they must all be on terms of close amity ; but it is not always easy to say which party is the borrower, and which the lender. We must however be so just as to instance one exception to this mutuality. Dr. Stillé deals rather sternly with Dr. Sternberg's adopted comma bacillus. He says : "It seems no longer possible to accept the bacillar doctrine of the production of cholera." In support of this negation he quotes Koch, on the mortality of the comma bacilli, where he has been so frank as to tell us, that, "even after three hours drying every vestige of life has disappeared." What! so fearfully killing, and yet so easily killed.

A PRACTICAL TREATISE ON URINARY AND RENAL DISEASES, INCLUDING URINARY DEPOSITS. Illustrated by Numerous Cases and Engravings. By William Roberts, M.D., F.R.S., F.R.C.P. (Lond.), Professor of Medicine at the Victoria University, etc., assisted by Robert Maguire, M.D., Lond., F.R.C.P., etc. Fourth Edition. Philadelphia : Lea Bros. & Co. ; Toronto : Vannevar & Co. Price, \$3.50.

The work before us is one we can recommend to those in need of a good reliable work on the

above named subject. It is already well known to the profession through former editions, and has been highly appreciated. The work is divided into three parts. The first part takes up the physical and chemical properties of the urine, in health and disease, and the methods of examining the same chemically and microscopically. The second part treats of "Urinary diseases" viz., diabetes, gravel, calculus and chylous urine, in which the author not only gives the results of his own experience, but also all recent accepted facts in connection with these diseases. The third and most valuable part is devoted to the consideration of organic diseases of the kidneys, acute and chronic. The entire work is of a clinical and practical character, and will be found a reliable guide in the treatment of these diseases.

BODILY DEFORMITIES AND THEIR TREATMENT, A HANDBOOK OF PRACTICAL ORTHOPÆDICS, by H. A. Reeves, F.R.C.S. Eng., London Royal Orthopædic Hospital, with 228 illustrations. Philadelphia: P. Blakiston Son & Co. Toronto: Willing & Co., \$2.25.

The author deals with his subject in a most thorough and comprehensive manner, and gives us the full benefit of his large and extended experience in the treatment of this class of affections. Some subjects quite new to British surgery will be found in this book, for example, "Spring Finger, Paralytic dislocations, new operation for Nasal Depression etc. The work has been written from the standpoint of a general surgeon interested in this special domain, and the author endeavors to show that success in the treatment of orthopædic cases depends very largely on extensive experience, personal supervision, and watchful care.

HAND-BOOK ON THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES, by Arthur Van Harlingen, M.D., Prof. of Skin Diseases; Philadelphia Polyclinic etc. Philadelphia: P. Blakiston Son & Co. Toronto: Willing & Co. Price \$1.75.

The above will be found a useful little work on skin diseases, adapted to the wants of the general practitioner. It is chiefly devoted to the clinical features, diagnosis and treatment of the various diseases. The diseases are taken up in alphabetical order, in order to facilitate ready reference.

THE OLEATES, THEIR NATURE AND ACTION, by J. V. Shoemaker, A.M., M.D., Prof. of Dermatology, Jefferson Medical College. Philadelphia: F. A. Davis, att'y. Toronto: Willing & Co.

SURGICAL PATHOLOGY, by A. J. Pepper, F.R.C.S., St. Mary's Hospital, London.

SURGICAL DIAGNOSIS, by A. P. Gould, F.R.C.S., Middlesex Hospital, London.

THE DISSECTOR'S MANUAL, by W. B. Clark and C. B. Lockwood, F.R.C.S., St. Bartholomew's Hospital.

INTESTINAL OBSTRUCTION AND TREATMENT, by Fred. Treves, F.R.C.S., London Hospital.

The above together with a work on *Materia Medica*, by Mitchell Bruce, constitute a series of clinical manuals for practitioners and students of medicine, published by Lea Bros. & Co, Philadelphia. They are edited by well known authorities in England, and issued in pocket size, 12 mo. volumes of 300 to 500 pages, well illustrated, and at a low price. The works are not pretentious, but will serve a useful purpose as books of reference on the subjects upon which they treat.

A TREATISE ON HEMORRHOIDAL DISEASE, ITS HISTORY, NATURE, CAUSES, DIAGNOSIS AND TREATMENT, by Wm. Bodenhamer, A.M., M.D. New York: Wm. Wood & Co. Toronto: Hart & Co.

We believe this is the only work on the subject of hemorrhoids published; at all events on this side of the Atlantic. This treatise will be found to be a complete encyclopædia on the subject, and will repay a careful perusal. As a work of reference it cannot be excelled.

HAY FEVER, AND ITS SUCCESSFUL TREATMENT BY SUPERFICIAL ORGANIC ALTERATION OF THE NASAL MUCOUS MEMBRANE. By Charles E. Sajous, M.D. Illustrated by 13 Wood Engravings. Philadelphia: F. A. Davis, 1217 Filbert Street.

Births, Marriages and Deaths.

On the 11th ult., Dr. J. W. Walden, of Waterloo, aged 47.

On the 20th ult., Dr. Joseph Mothersill, of Stratford, aged 65 years.

On the 28th ult., H. L. Vercoe, M.D., of Toronto, aged 45 years.

On the 20th ult., Fanny Creighton, beloved wife of Dr. L. F. Millar, of Woodhill, aged 28 years.

